

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mrs. Pauline (NMN) Adams</b>		4. DATE OF DEATH Month Day Year <b>July 12 19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1903</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>Frank Mavis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Eliza</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-14-7250</b>	
17. INFORMANT <b>Patient's chart</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> DUE TO (b) <b>vomited</b> DUE TO (c) <b>gastric dilatation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Strains hernia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/19</b> , 19 <b>66</b> , to <b>7/12</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>7/12</b> , 19 <b>66</b> , and that death occurred at <b>11:04 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Kenneth Crige</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>7-15-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>George R. Brunden</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 18 1966</b>	
ADDRESS <b>Rockville</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10034

0000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10043

10035

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN TB <b>10 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		15 - 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12801 Leahy Drive</b>		d. STREET ADDRESS <b>12801 Leahy Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Wilson ALEXANDER</b>		4. DATE OF DEATH Month Day Year <b>JULY 19 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 22, 1905</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>1 27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber Shop</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Bernard Alexander</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hockersmith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-14-1225</b>	
17. INFORMANT <b>Ruth F. Alexander-Same as Item #2-Wife</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> DUE TO <b>myocardial infarction</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>58</b> to <b>July 19</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>July 18</b> , 19 <b>66</b> , and that death occurred at <b>5:57 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Wilfred R. Ehrmantraut</b> M.D.		22b. DATE SIGNED <b>7/20/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantraut</b>		22d. ADDRESS <b>1125 Rockville Pike, Rockville</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/22/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>JUL 22 1966</b>	

10035

THE CITY OF TOWN

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035

10035



## CERTIFICATE OF DEATH

10044

10036

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>2517 Buck Lodge Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Allen</u>		4. DATE OF DEATH <u>7-29-66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/81</u>
9. AGE (In years last birthday) <u>84</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Cook</u>		14. MOTHER'S MAIDEN NAME <u>Loretta Tippet</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>son Harry Allen</u>		Address <u>Hyattsville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>12 hrs</u> <u>Indef</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gm. arteriosclerosis &amp; gangrene of H. ft.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/61</u> to <u>7/29/66</u> , that (I) (we) last saw the deceased alive on <u>7/29/66</u> , and that death occurred at <u>2:38</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen N. Jones</u>		22b. DATE SIGNED <u>7/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>		22d. ADDRESS <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 1, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>AUG 1 1966</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

35991

1222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10045					10037						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY <b>Montgomery</b>					a. STATE <b>New York</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					b. COUNTY <b>Flushing</b>						
c. LENGTH OF STAY IN 1b <b>118 Days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bayside</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>					d. STREET ADDRESS <b>211-02 73rd Avenue</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<b>Saul</b>		<b>Robert</b>		<b>Alterman</b>		Month <b>July</b>		
									Day <b>19</b>		
									Year <b>1966</b>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>Male</b>		<b>White</b>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>13 June 1899</b>		<b>67</b> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Louis Alterman</b>						14. MOTHER'S MAIDEN NAME <b>Rachel Katz</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>Not Available</b>		17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Post thymectomy for thymoma</b> DUE TO (c) <b>Agammaglobulinemia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>5 years</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic diarrhea with wasting</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>23 March, 1966</b> to <b>19 July, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>19 July, 1966</b> , and that death occurred at <b>4:22M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <i>R. Michael Blaese</i>								A.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>19 July, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. Michael Blaese, M.D.</b>								22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>7-20-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth David Cem</b>			23d. LOCATION (City, town or county) (State) <b>Elmont L.I. New York</b>			
24. FUNERAL DIRECTOR <b>I. J. Morris Inc</b>						ADDRESS <b>9701 Church Ave. Bklyn N.Y.</b>		25a. REC'D BY REGISTRAR <b>JUL 22 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10046						10038					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montg.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens</i>						d. STREET ADDRESS <i>6819 Delaware St.</i>					
3. NAME OF DECEASED (Type or print) <i>CORILLA Johns Anderson</i>						4. DATE OF DEATH <i>July 17 1966</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 9 1868</i>		9. AGE (In years last birthday) <i>97</i> yrs.		10. IF UNDER 1 YEAR	
								Months <i>11</i> Days <i>8</i> Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John William Byrne</i>						14. MOTHER'S MAIDEN NAME <i>Sarah Ellen Dowden</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Paul S. Anderson - Same Item #2</i>				Address <i>SON</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Congestive failure</i> DUE TO (c) <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Broncho pneumonia</i>										INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 65</i> to <i>present</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7/17/66</i> 19 <i>66</i> , and that death occurred at <i>9:50 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Jay R. Shapiro</i>						22b. DATE SIGNED <i>7/18/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>Jay R. Shapiro, M.D.</i>						22d. ADDRESS <i>8218 Wisconsin Ave Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>7/20/1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Gaithersburg Maryland</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>						ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>J Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	

10035

10035

Handwritten notes and signatures at the top of the page, including a signature that appears to be "H. H. H."

Handwritten notes and signatures in the middle section, including a signature that appears to be "H. H. H."

Handwritten notes and signatures at the bottom of the page, including a signature that appears to be "H. H. H."



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN ID <b>10 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			d. STREET ADDRESS <b>3904 Elby Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Bruce Patrick Angelo</b>			4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 66</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3 November 1956</b>		9. AGE (In years last birthday) <b>9</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas P. Angelo</b>					14. MOTHER'S MAIDEN NAME <b>Alice Praskavich Praskavich</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Md. 20014</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> 5834 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hepatitis, unknown etiology</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gastric ulceration; Acute lymphocytic leukemia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> <b>14 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>June 27</b> , 19 <b>66</b> , to <b>July 7</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>July 7</b> , 19 <b>66</b> , and that death occurred at <b>6:55M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Myron J. Levin</b>					A. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. <b>7 July 1966</b>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Myron J. Levin, M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>July 11, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>C. Glenn Carter</b> <b>Warner E. Pumphrey, Inc.</b>					25a. REC'D BY REGISTRAR <b>8434 Georgia Ave.</b> <b>Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

Montgomery	Bethesda	10 days	Maryland	Silver Spring	Montgomery
The Clinical Center, Bethesda, Maryland	3900 Riva Street	July 7, 66	Angelo	Patrick	Prince
Male	White	3 November 1955	USA	Washington, D.C.	USA
Student	Thomas I. Angelo	Notes	The Clinical Center, Bethesda, Md. 20014	The Medical Record	Alice G. Grawsky
no	---	Hepatic failure	14 days	Hepatitis, unknown etiology	14 days
Gastric ulceration; Acute lymphocytic leukemia					
July 7, 66	June 27	July 7, 66	July 7, 66	July 7, 66	July 7, 66
Myron J. Levin, M.D.					
Institute of Health, Bethesda, Maryland	The Clinical Center, National				

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10048

CERTIFICATE OF DEATH

10040

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN TB <i>DOA</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>						d. STREET ADDRESS <i>4720 Cherry Chase Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Cecilyn Appleby</i>						4. DATE OF DEATH Month <i>7</i> Day <i>6</i> Year <i>1966</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>w</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-17-1890</i>		9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Sigel</i>						14. MOTHER'S MAIDEN NAME <i>-</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>				16. SOCIAL SECURITY NO. <i>579-60-3249</i>		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> , to <i>7-6-66</i> , that (I) (we) last saw the deceased alive on <i>7/5</i> 19 <i>66</i> , and that death occurred at <i>3:00</i> M, from causes on and on the date stated above.											
22a. SIGNATURE <i>Paul J. Carlos</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Paul J. Carlos</i>						22d. ADDRESS <i>4709 Montgomery Lane, Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>7-9-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Md.</i>			
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc. Wash. D.C.</i>						25a. REC'D BY REGISTRAR DATE <i>JUL 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10040

MINISTRY OF DEFENSE

10040

1. Name of the person or organization to whom the document is addressed

2. Address of the person or organization to whom the document is addressed

3. City, State, and Zip Code of the person or organization to whom the document is addressed

4. Country of the person or organization to whom the document is addressed

5. Date of the document

6. Subject of the document

7. Name of the person or organization issuing the document

8. Address of the person or organization issuing the document

9. City, State, and Zip Code of the person or organization issuing the document

10. Country of the person or organization issuing the document

11. Date of the document

12. Subject of the document

13. Name of the person or organization issuing the document

14. Address of the person or organization issuing the document

15. City, State, and Zip Code of the person or organization issuing the document

16. Country of the person or organization issuing the document

17. Date of the document

18. Subject of the document

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10049

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10041

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12209 CENTERHILL ST</b>				d. STREET ADDRESS <b>12209 CENTERHILL ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VALARIE</b> Middle <b>ANN</b> Last <b>ARNOLD</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>1966</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-1961</b>		9. AGE (In years last birthday) <b>5</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>15</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Houston, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WALTER FLOYD ARNOLD</b>				14. MOTHER'S MAIDEN NAME <b>MARY MARGARET WALTERS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MRS LEE HILDEBRAND</b>		Address <b>804 Burlington Ave S. S., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9250 Acute asphyxiation due to suffocation, accidental</b> DUE TO (b) <b>to suffocation, accidental</b> DUE TO (c) <b>to suffocation, accidental</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Child hid in dryer chest and was unable to get free.</b>					
20c. TIME OF INJURY Month, Day, Year <b>4:00 a.m. 7-6-1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Back yard</b>		20f. (City or town) <b>Silver Spring</b> (County) <b>Montgom.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>July 6, 1966</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Rockville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b> ADDRESS <b>8434 Georgia Ave.</b>				25a. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

14001

14001

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



## CERTIFICATE OF DEATH

10050

10042

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>USA Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>14112 CHADWICK LANE</u>	
3. NAME OF DECEASED (Type or print) <u>Middred E Baden</u>		4. DATE OF DEATH <u>7</u> Month <u>16</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/01</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Wm. Rawlings</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Washington Perrie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-7734</u>	
17. INFORMANT <u>Mrs. Geo. H. L'Heureux - same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Nephroses, Scleroderma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>66</u> , to <u>7/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/15</u> , 19 <u>66</u> , and that death occurred at <u>1:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Barton J. Gershen</u>		22b. DATE SIGNED <u>7/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BARTON J. GERSHEN M.D.</u>		22d. ADDRESS <u>TENLEY BLDG. ROCKVILLE, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 19, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Md.</u>	
24. FUNERAL DIRECTOR <u>H. Don DeLo</u>		25a. REC'D BY REGISTRAR <u>2224 Wisc. Ave. NW</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>JUL 21 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10043

20020

COAST GUARD FIRE

U.S. DEPARTMENT OF COMMERCE

10051

CERTIFICATE OF DEATH

10043

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4520 Cheltenham Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>A</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/07</u>
9. AGE (In years, last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ins. Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Met. Life</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Everett C. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Abbie Godbout</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wife Rebecca (Same as above)</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, TERMINAL</u> DUE TO (b) <u>METASTATIC CARCINOMA, LIVER</u> DUE TO (c) <u>CARCINOMA OF LUNG</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>4 MONTHS</u> <u>1 YEAR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 10, 1948</u> , to <u>JULY 10, 1966</u> , that (I) (we) lost the deceased alive on <u>JULY 10, 1966</u> , and that death occurred at <u>12:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>7-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>		22d. ADDRESS <u>5009 Del Ray Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/13/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Darnestown Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>JUL 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10045

10031

RECEIVED OF DUNN

RECEIVED

5009 Del Rio Ave., Baltimore, Md.

Robert C. Anglin, A. L.

Pennington Cemetery

Pennington Cemetery

7/13/1958

2-131

Robert C. Anglin, A. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Charles E. M. Keap / J.S.P.H.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10052					10044						
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> c. LENGTH OF STAY IN 1b <u>2 mos 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2601 Jennings Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Arthur W.</u>			4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1966</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/24/89</u>		9. AGE (In years last birthday) <u>76</u> yrs. <u>9</u> Months <u>9</u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if any is required) <u>Water Dept.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXXXXXXXX</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Charles Ball</u>					14. MOTHER'S MAIDEN NAME <u>Janie Keys</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>220-44-5436</u>		17. INFORMANT <u>2601</u> Address <u>Jennings Road</u> <u>Eulalie B. Lewis, Silver Spring, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>465X</u> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>May 28, 1966</u> to <u>July 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1966</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>George L. Ball</u>					22b. DATE SIGNED <u>July 29, 1966</u>						
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>					22d. ADDRESS <u>10620 Ga. Ave. Silver Spring, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>			23d. LOCATION (City, town or county) (State) <u>Herndon, Virginia</u>				
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>AUG 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

5200

1

8.10.10 7.600.154

10000 20000 30000 40000 50000 60000 70000 80000 90000 100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10053					10045						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>43 Days</b>		a. STATE <b>Massachusetts</b>		b. COUNTY <b>Lynn</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Swampscott</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <b>Abbe</b>		Middle <b>Lynne</b>		Last <b>Baren</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 66</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 January 1958</b>		9. AGE (In years last birthday) <b>8 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Carl Baren</b>					14. MOTHER'S MAIDEN NAME <b>Alice Burkam</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Retroperitoneal lymphoma (Burkitt's type)</b> 2021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>None</b> DUE TO (c) <b>None</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>										INTERVAL BETWEEN ONSET AND DEATH <b>7 Weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 10</b> , 19 <b>66</b> , to <b>23 July</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>23 July</b> , 19 <b>66</b> , and that death occurred at <b>11:35 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Leonard H. Brubaker</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>P.M.</b>		22b. DATE SIGNED <b>24 July 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leonard H. Brubaker</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>7/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pride of Lynn</b>			23d. LOCATION (City, town or county) (State) <b>Lynn, Mass.</b>				
24. FUNERAL DIRECTOR <b>Sol Leimov &amp; Bros Inc 6010 Rust. Road</b>						25a. REC'D BY REGISTRAR <b>JUL 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

*M. J. Griffin*

The Clinical Center, Bethesda, Maryland, is the only drive

5407

1822

у.т.т.

Female White

8 5291 vernal 9

2520

194/22

000000

Alive Again

The Medical Records,

The Clinical Center, Bethesda, Maryland

Neurophysiologische Grundlagen (S. 1-10)

1917, 1918

Of our

20:11

• • •

γ, 1.0, 1.0

The Original Center, Montreal,  
Institute of Health, Montreal, 1971

Leonard H. Glicker

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10054

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10046

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, 15-1</u>	
c. LENGTH OF STAY IN lb <u>D. O. A.</u>		d. STREET ADDRESS <u>415 Ellsworth Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>R.</u> Last <u>BASS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov.</u>	9. AGE (In years last birthday) <u>67 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Harrisonburg, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jacob R. Randolph</u>		14. MOTHER'S MAIDEN NAME <u>Mary Branum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>217-44-0553</u>	
17. INFORMANT <u>Mrs. Lloyd Wingard, Box 32, Elkton, Va.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>7/30/1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 2, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>
23d. LOCATION (City or town) (County) (State) <u>Prince Georges Co., Md.</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2202

1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>9 Hours</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					d. STREET ADDRESS <b>8305 Raymond Lane</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Barbara</b>			First <b>(NMN)</b> Middle <b>Beck</b> Last		4. DATE OF DEATH <b>July 13 1966</b>		Month <b>July</b> Day <b>13</b> Year <b>1966</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 July 1953</b>		9. AGE (In years last birthday) <b>12</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert A. Beck</b>					14. MOTHER'S MAIDEN NAME <b>Luz Alago</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram negative septicemia ?</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Enterocolitis, drug induced</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b> <b>3 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute lymphocytic leukemia, relapse (3 years)</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>13 July</b> , 19 <b>66</b> , to <b>13 July</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>13 July</b> , 19 <b>66</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Myron J. Levin</b>					22b. DATE SIGNED <b>July 14, 1966</b>			22c. PHYSICIAN'S NAME (Type) <b>Myron J. Levin, M.D.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>7/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town or county) (State) <b>Silver Spring, Maryland</b>		
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>					25a. REC'D BY REGISTRAR <b>JUL 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10056

CERTIFICATE OF DEATH

10048

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MD. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASH., D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CITY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CITY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CHEVY CHASE NURISING HOME</b>		d. STREET ADDRESS <b>47-3</b>	
3. NAME OF DECEASED (Type or print) <b>RUTH</b> First <b>M.</b> Middle <b>BETTS</b> Last		4. DATE OF DEATH <b>JULY</b> Month <b>2</b> Day <b>1966</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>OCT. 5, 1891</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PAINT CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>KANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN (UNK.)</b>		14. MOTHER'S MAIDEN NAME <b>LORETTO (UNK.)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-46-5717</b>	
17. INFORMANT <b>ALINE FULNAS</b> Address <b>4200 CATH. AVE. WASH.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4201</b> DUE TO <b>coronary arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>unk.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB</b> , 1966 to <b>JUL 2</b> , 1966 that (I) (we) last saw the deceased alive on <b>JUL 1 1966</b> and that death occurred at <b>3:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert S. Poole</b>		22b. DATE SIGNED <b>7-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT S. POOLE</b>		22d. ADDRESS <b>4501 CONN. AVE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-4-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>DAKWOOD CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>RICHMOND, VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>JOSEPH GAWLERS SONS</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 8 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10000

10000

10000

10000

10000

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10057					10049									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Montgomery					a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park					b. COUNTY Montgomery									
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hospital					d. STREET ADDRESS 302 Patterson Court									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE					
First Baby			Middle Girl			Last Birlew			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>					
8. DATE OF BIRTH 7-11-66			9. AGE (In years last birthday) 7 yrs.			10. IF UNDER 1 YEAR Months 1 Days 8			11. IF UNDER 24 HRS. Hours 15 Min. 45					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Takoma Park, Maryland				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Dennis Newton Birlew					14. MOTHER'S MAIDEN NAME Delores Alline Wilson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO.					17. INFORMANT Mother's record				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) APNEA														
7625 DUE TO PREMATURITY (EST. GESTATION 28-30 WKS)														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 7-11, 1966, to 9:10 PM, 1966, that (I) (we) last saw the deceased alive on 5:20 PM 7-12, 1966, and that death occurred at 9:10 PM, from the causes and on the date stated above.														
22a. SIGNATURE G. Mirkin					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) G. MIRKIN, MD					22d. ADDRESS 1110 Spring St. Silver Spring, Md.			22b. DATE SIGNED 7-12-66						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Wash. San. & Hospital			23d. LOCATION (City, town or county) (State) Takoma Park Maryland						
24. FUNERAL DIRECTOR Mr. H. S. Nelson					25a. REC'D BY REGISTRAR DATE JUL 18 1966			25b. REGISTRAR'S SIGNATURE J. Charles Judge						

10019

10023



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10058					10050									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
e. COUNTY		MONTGOMERY			e. STATE		b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. IS RESIDENCE ON A FARM?							
SILVER SPRING					WASHINGTON DC		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS									
BETHESDA - SILVER SPRING NURSING HOME					45-45 CONN. AVE. N.W.									
3. NAME OF DECEASED					4. DATE OF DEATH									
(Type or print)					Month Day Year									
EVA					BLOOMBERG JULY 21 1966									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 15 - 1898		68 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?								
HOUSEWIFE				GEORGIA		USA								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
ISRAEL SILVERMAN					ZELDA FREEDMAN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
NO										HUSBAND				
					ABE E. BLOOMBERG					45-45 CONN AVE NW				
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (e)										metastatic disease to lung + bones				
163X										4 mos				
CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.										2 1/2 yrs				
DUE TO (b) Carcinoma of lung														
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, lecture, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Aug 1966 to 7/21 1966 that (I) (we) last saw the deceased alive on 7/19 1966, and that death occurred at 10:30 PM, from the causes and on the date stated above.														
22a. SIGNATURE										22b. DATE SIGNED				
MORRIS H. ROSENBERG M.D.										7/21/66				
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS				
MORRIS H. ROSENBERG										2025 EYE ST NW				
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF				
BURIAL										7-24-66				
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)				
KING DAVID MEMORIAL GARDEN - FALLS CHURCH VA.														
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR				
BERNARD DANZANSKY & SONS WASH. DC										25b. REGISTRAR'S SIGNATURE				
										DATE AUG 1 1966 J. Charles Judge				

10000

10000

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

10059

CERTIFICATE OF DEATH

10051

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Hrs. 15 mrs. Poolesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Rt. # 1</u>	
3. NAME OF DECEASED (Type or print) <u>Charles R. Bodmer</u>		4. DATE OF DEATH <u>July 2 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/92</u> 13 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter carrier government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Bodmer</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Wiles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>W.W.I. Army</u>		16. SOCIAL SECURITY NO. <u>214-46-6767</u>	
17. INFORMANT <u>Lad &amp; Bodmer</u>		Address <u>as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>6 1/2 hours</u> (b) <u>Myocardial infarction</u> (c) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> to <u>July 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 2</u> , 19 <u>66</u> , and that death occurred at <u>9:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Fawcett</u>		22b. DATE SIGNED <u>7/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John S. Fawcett</u>		22d. ADDRESS <u>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/6/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Manacacy</u>		23d. LOCATION (City or Town) (County) (State) <u>Beallsville Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Edna C. Hillman</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Edna C. Hillman</u>		25c. REGISTRAR'S SIGNATURE <u>Edna C. Hillman</u>	

12041

22031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10060						10052					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Prince George's</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>POTOMAC MD.</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>HILLSIDE</i> 16-2					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>POTOMAC MANOR NURSING HOME 9807 RIVER RD.</i>						d. STREET ADDRESS <i>1236-55<sup>th</sup> AVE.</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <i>George Hartwell Boley</i>			4. DATE OF DEATH Month Day Year <i>July 17 1966</i>								
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>26 May 1877</i>		9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>STOCK CLERK</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>RETAIL DEPARTMENTAL</i>				11. BIRTHPLACE (County & State, or foreign country) <i>VIRGINIA</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>											
13. FATHER'S NAME <i>HARTWELL BOLEY</i>						14. MOTHER'S MAIDEN NAME <i>MARY FRANCES SMALLWOOD</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>UNK.</i>		17. INFORMANT <i>ANNE V. CHAPEL</i>		Address <i>343 RALEIGH ST. S.E., WASH., D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>On Throat static Pneumonia</i> <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arteriosclerosis</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>July 11, 1966</i> , to <i>July 17, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 14, 1966</i> , and that death occurred at <i>9P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John D. Herman</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7/17/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>John D. Herman</i>						22d. ADDRESS <i>Bethesda, Md. 4801 Montgomery Lane</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>20 JULY 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CONGRESSIONAL CEMETERY</i>		23d. LOCATION (City, town or county) (State) <i>WASHINGTON DC.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>WALDI FUNERAL HOME 7400 GEORGIA AVE. NW. WASH. D.C.</i>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE <i>JUL 21 1966</i>											

10052

CERTIFICATE OF DEATH

10052

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS 301 N. MICHIGAN STREET, BALTIMORE 1, MARYLAND

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
John D. Hoffman		Male		45		White		April 15, 1945		Home	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
Physician		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. SEX		16. RACE		17. RELIGION		18. EDUCATION	
New York		April 15, 1900		Male		White		Catholic		High School	
19. MARITAL STATUS		20. PREVIOUS MARRIAGES		21. DATE OF MARRIAGE		22. NAME OF SPOUSE		23. NAME OF CHILDREN		24. NAME OF GRANDCHILDREN	
Married		1		April 15, 1925		Mary D. Hoffman		John D. Hoffman, Jr.		Mary D. Hoffman, Jr.	
25. DATE OF INTERVIEW		26. NAME OF INTERVIEWER		27. NAME OF WITNESSES		28. NAME OF REGISTRAR		29. NAME OF PHYSICIAN		30. NAME OF CLERK	
April 15, 1945		John D. Hoffman		Mary D. Hoffman		John D. Hoffman		John D. Hoffman		John D. Hoffman	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health. The information furnished on this certificate is for statistical purposes only and is not to be used for legal purposes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10061					10053				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross</u>					d. STREET ADDRESS <u>9437 Curran Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willard A. Botzum</u>		First <u>Willard A.</u> Middle <u>Botzum</u> Last <u>S.P.</u>		4. DATE OF DEATH <u>July 5</u> 19 <u>66</u>		Month <u>July</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/17/87</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reading Railroad (Retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Car Insp.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Botzum</u>					14. MOTHER'S MAIDEN NAME <u>Mary Stock</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>715-16-5844</u>		17. INFORMANT <u>Jern Seidel</u>		Address <u>9437 Curran Rd., S. S., Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Congestion</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> (c) <u>Artificially induced heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes - Mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>11 days</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> , 19 <u>66</u> , to <u>7/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/5/66</u> , 19 <u>66</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Francis X. Richardson</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/5/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Francis X. Richardson</u>					22d. ADDRESS <u>11412 Viers Mill Road, Bethesda Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>July 9, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laureldale Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Reading, Pennsylvania</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Ave.</u>					25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		





1  
2  
FOR STATE HEALTH DEPT.

10062

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10054

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10320-Jawcett <del>House</del> Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>XR B.</u> Last <u>Bowman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1886</u>	9. AGE (In years last birthday) <u>80</u> yrs.	10. FUNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. FUNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>		
13. FATHER'S NAME <u>Charles Smith</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-56-1942</u>		17. INFORMANT <u>Mrs. Jane Gibson</u> Address <u>10320 Jawcett Street Kensington, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident - Aphasia</u> <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, generalized.</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>7/31/1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Wheaton</u>		Address (Street, city, town, or county) <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 3, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>Colesville, Maryland</u>				
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>  </u>		

10054

MEDICAL EXAMINER - CERTIFICATE OF DEATH

5-10-54

NAME OF DECEASED: [illegible]

RESIDENCE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF EXAMINATION: [illegible]

PLACE OF EXAMINATION: [illegible]

REMARKS: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10063

## CERTIFICATE OF DEATH

10055

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>5 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>1000 W. Beck Dr.</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>T</i> Last <i>Bradley</i>		4. DATE OF DEATH Month <i>7</i> Day <i>4</i> Year <i>1966</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/20/12</i>
9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>14</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerical</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Navy</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Stonewall Okla.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Edmund Bradley</i>		14. MOTHER'S MAIDEN NAME <i>Lula E. Blasingame</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>440-07-5535</i>	
17. INFORMANT <i>Nita Bradley</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic adenocarcinoma</i> <i>1538</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>adenocarcinoma - colon</i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 1966, to <i>7-4</i> , 1966, that (I) (we) last saw the deceased alive on <i>7-4</i> , 1966, and that death occurred at <i>3:45 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>D.L. Bucy / R. Macon</i>		22b. DATE SIGNED <i>7-4-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>D.L. Bucy / R. Macon</i>		22d. ADDRESS <i>804 Veirs Mill Rd Rockville Montg</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>7/7/1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville Montg. Maryland</i>
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
25a. REC'D BY REGISTRAR <i>JUL 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10055

10055

Brady

440-07-5585

Rockville Cemetery

7/7/1986

Brady

Robert A. Brady, Bethesda, Maryland

## CERTIFICATE OF DEATH

10056

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>3811 39th St N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>MILDRED</u> Middle <u>KENNEY</u> Last <u>BRADY</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-09</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REGISTERED NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NURSING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter T. Kenney</u>		14. MOTHER'S MAIDEN NAME <u>CECILIA JANE BRODERICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Husband-FRANK Plabore-SAME AS # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm, ruptured, cerebral (communicating branch)</u> 330X DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>  </u> to <u>July 18, 1966</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>July 17, 1966</u> , and that death occurred at <u>3:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>DeWitt E. DeLauter</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLauter</u>		22d. ADDRESS <u>3848 Porter St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-21-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAEL'S CH. CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>FROSTBURG, MD.</u>	
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, WASH., D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 22 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0700 :

2702



10065

## CERTIFICATE OF DEATH

10057

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>11 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. STREET ADDRESS <b>Box 108</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Filoura</b> Last <b>Brashear</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-5-89</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>12</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sylvester Marnes</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Drockway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-44-4845</b>	
17. INFORMANT <b>Mrs. Viola Thompson Carmichaels, Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> minutes to hours. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary Artery Disease</b> 2 years. DUE TO (c) <b>Arteriosclerosis</b> years.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gastric bleeding with anemia due to blood loss 1 wk.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/4/66</b> , to <b>7/12/66</b> , that (I) (we) last saw the deceased alive on <b>7/11/66</b> , and that death occurred at <b>2:20am</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Richard A. Yates</b>		22b. DATE SIGNED <b>7/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. R.A. Yates</b>		22d. ADDRESS <b>OLNEY, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-14-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Kempton</b>		23d. LOCATION (City or Town) (County) (State) <b>Kempton, Maryland</b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1966</b>	
ADDRESS <b>Laytonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10053

10062

SECTION OF DEATH

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

10053

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10066

10058

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN ID <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Maryland</b>				e. STREET ADDRESS <b>127 Forrest Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>D</b> Last <b>BRAWNER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 13, 1923</b>	9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Frankfort, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dennis Vernon Brawner</b>				14. MOTHER'S MAIDEN NAME <b>Rose Pearl Downey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1941-1966</b>		17. INFORMANT <b>Mrs. Clara M. Brawner, 127 Forrest Ave.,</b>		Address <b>Norfolk, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonitis</b> <b>5271</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cor pulmonale, Acute</b> DUE TO (c) <b>Pulmonary emphysema- Chronic</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>  <b>2 hours</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John G. Ball</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John G. Ball, M. D.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-15-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Norfolk, Virginia</b>	
24. FUNERAL DIRECTOR ADDRESS <b>W. W. Chambers Funeral Home, 1400 Chapin St., N. W. Washington, D. C.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10478

PHYSICAL EXAMINER'S REPORT

10478

10478

10478

10478

10478

10478

10478

10478

U. S. Naval Hospital, Honolulu, Territory of Hawaii

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

10478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10067						10059					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>PIECES</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIECES</u> 42-3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>3507 Ave J</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>P.</u> Last <u>BRENNAN</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>3</u> Year <u>1966</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-18-88</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired RR Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RR Engineer Railroad</u>				11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Brennan</u>						14. MOTHER'S MAIDEN NAME <u>Mary McMahon</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>John J. Brennan-Son- Kensington, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pul. failure</u> 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>pul. metastases</u> DUE TO (c) <u>Carcinoma of colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>24h</u> <u>1 min</u> <u>1 yr</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>65</u> to <u>7/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> , 19 <u>66</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Stephen N. Jones</u>						22b. DATE SIGNED <u>7/3/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones, M.D.</u>						22d. ADDRESS <u>Rockville, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/6/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>			
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Robert A. Humphrey Bethesda, Maryland

Entire 7/6/1966 Gate of Heaven Silver Spring, Maryland

Stephen K. Jones, M.D.

NO Unknown John J. Brennan-John - Kensington, Md.  
3180 Plover Way NE, Mary Washington

Bellevue WA 33-31-7  
USA



1  
M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>909 Prospect Street</b>	
3. NAME OF DECEASED (Type or print) First <b>David</b>		Middle <b>Samuel</b>		Last <b>Brock</b>	
4. DATE OF DEATH Month <b>July</b>		Day <b>2,</b>		Year <b>19 66</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>25 June 1944</b>		9. AGE (In years last birthday) <b>22 yrs.</b>		IF UNDER 1 YEAR Months <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles H. Brock</b>		14. MOTHER'S MAIDEN NAME <b>Ethel L. Tompkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-24-4218</b>		17. INFORMANT <b>The Medical Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Glioblastoma multiforme</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Urinary tract infection</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <del>the</del> (this hospital) attended the deceased from <b>June 9</b> , 19 <b>66</b> , to <b>July 2</b> , 19 <b>66</b> , that <del>we</del> (we) last saw the deceased alive on <b>July 2</b> , 19 <b>66</b> , and that death occurred at <b>12:20</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward Tarlov</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward Tarlov, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>July 5-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Memorial Park</b>	
23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>		24. FUNERAL DIRECTOR <b>Northwell</b>			
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10000

10000

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

THE OFFICIAL GAZETTE, NEWSPAPER, LONDON, 1900

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10063

10061

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Sanitarium</b>		d. STREET ADDRESS <b>4317 Saul Road</b>	
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>N.</b> Last <b>BROE</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1882</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>John Bonython</b>	
14. MOTHER'S MAIDEN NAME <b>Sara Walsh</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Son</b> <b>William V. Broe</b> Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 17, 1965</b> , to <b>JULY 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>JULY 14, 1966</b> , and that death occurred at <b>4:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Henry M. Lowden</b>		22b. DATE SIGNED <b>7-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>		22d. ADDRESS <b>5206 NORWAY DR. CHEVY CHASE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>	23b. DATE THEREOF <b>7-16-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Amesbury, Mass.</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10061

10061

LETTERHEAD OF DEATH

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

NOVEMBER 1942

10070

## CERTIFICATE OF DEATH

10062

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Sanitarium</b>		d. STREET ADDRESS <b>9020 Fairview Road</b>	
3. NAME OF DECEASED (Type or print) <b>GRACE Lee BROOME</b>		4. DATE OF DEATH <b>JULY 25 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>24</b> IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Darnestown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexander Broome</b>		14. MOTHER'S MAIDEN NAME <b>Mary Warfield</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Miss Nelle Broome-Niece-Same Item #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB 4, 1948</b> , to <b>JULY 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>JULY 25, 1966</b> , and that death occurred at <b>12:40 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Henry M. Lowden</b>		22b. DATE SIGNED <b>JULY 25, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry M. Lowden, M.D.</b>		22d. ADDRESS <b>5206 Parkway Dr. Chevy Chase, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/27/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Darnestown Pres. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Darnestown Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUL 28 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

10000

Montgomery

MARY ANN

Montgomery

Pennington

Silver Spring

Carroll Hall Sanitation

2030 Fairview Road

Lee

Female White

May 1, 1891

2

23

None

None

Annapolis, Maryland

USA

Alexander Thomas

Mary Yarbrough

NO

Unknown

Miss Nellie Thomas-Nice-Young Item 11





10007

RECEIVED

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10007

10072

## CERTIFICATE OF DEATH

10064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>51 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4808 Cherry Chase Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Mabel E. Brubaker</u>		DATE OF DEATH <u>7</u> - Month <u>11</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>92</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Edwin Brake</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ballentine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>Mrs. Frances Felt</u>		Address <u>32nd Ave 2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO (b) <u>Congenital Polycystic Kidneys</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>7571</u>			INTERVAL BETWEEN ONSET AND DEATH Years <u>-</u> Years <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 19 <u>66</u> , to <u>July 11</u> , 19 <u>66</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>July 10</u> , 19 <u>66</u> , and that death occurred at <u>4:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James W. Egan</u>		22b. DATE SIGNED <u>July 11-1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES W. EGAN</u>		22d. ADDRESS <u>7720 Wisc Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>7-14-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>5130 Wisc. Ave. N.W., Wash. DC.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUL 18 1966</u>			

1301

3502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PP - cleared Dr. John Ball

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10073					10065				
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>COR-LU NURSING HOME</u>					d. STREET ADDRESS <u>6716 Knollbrook Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>SARAH</u> Middle <u>SALLIE</u>		Last <u>FLORENCE BRUNING</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>14</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/1871</u>	9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SOUTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>TIMOTHY W. HARLEY</u>				14. MOTHER'S MAIDEN NAME <u>EXCEY FOSTER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>NONE</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD</u> <u>4200</u> DUE TO <u>Generalized A.S.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>15 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <u>W</u> (this hospital) attended the deceased from <u>2-9</u> , 19 <u>66</u> to <u>7-14</u> , 19 <u>66</u> , that <u>X</u> (we) last saw the deceased alive on <u>7-6</u> , 19 <u>66</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>D. J. Sengstack M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-14-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. F. SENGSTACK</u>				22d. ADDRESS <u>9241 COLUMBIA BLVD. SILVER SPRING</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg Md</u>			
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO</u>				ADDRESS <u>Silver Spring Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10001

10003

Handwritten notes, mostly illegible due to fading and bleed-through. Some words like "Handwritten" and "Notes" are faintly visible.

Handwritten notes, mostly illegible due to fading and bleed-through. Some words like "Notes" and "Handwritten" are faintly visible.

Handwritten notes, mostly illegible due to fading and bleed-through. Some words like "Notes" and "Handwritten" are faintly visible.

Vertical handwritten text on the right margin, possibly a date or page number, including "10/10/10".



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
10074					CERTIFICATE OF DEATH					10066				
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>					15-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Resmor Sanitarium and Hospital</b>					4. STREET ADDRESS <b>11404 Rokeby Avenue Bethesda, Md.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MRS. CLARA BOGART BURRAGE</b>					4. DATE OF DEATH <b>July 27,</b> 19 <b>66</b>									
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>December 15, 1886</b>		9. AGE (In years lost birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY -- --			11. BIRTHPLACE (County & State, or foreign country) <b>New York City</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John B. Bogart</b>					14. MOTHER'S MAIDEN NAME <b>Adeline Johnson</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>			16. SOCIAL SECURITY NO. <b>072-01-6841</b>		17. INFORMANT Address <b>-B/ John D. Burrage-See Item No.2</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500 Congestive Heart Failure</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Nodular Lesions</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>Several months</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4/1/66</b> , 19 <b>66</b> to <b>7/27/66</b> , that (I) (we) last saw the deceased alive on <b>7/27/66</b> , and that death occurred at <b>12:45 A.M.</b> from causes and on the date stated above.														
22a. SIGNATURE <b>Stephen F. Verges</b>			M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/27/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Stephen F. Verges</b>			22d. ADDRESS <b>Resmor Sanitarium</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>7-29-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>						
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>					ADDRESS <b>5130 Wise Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

10060

CERTIFICATE OF DEATH

10074

MONTGOMERY

MONTGOMERY

MONTGOMERY

Montgomery

Montgomery

Montgomery, Alabama

Montgomery and Hospital

July 27, 1963

MISS. CLARA BOKART BURRAGE

December 12, 1963

U.S.A.

New York City

Montgomery

Adeline Johnson

John E. Brown

U.S.A. - New York City

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)  
6M 1/66

10075

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10067

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Mont. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>804-Grandin Avenue</b>		d. STREET ADDRESS <b>804 Grandin Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Atlee I. Burroughs</b>		4. DATE OF DEATH Month Day Year <b>July 18 1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1906</b> 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical App.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George C. Burroughs</b>		14. MOTHER'S MAIDEN NAME <b>Cora May Moulden</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-09-3213</b>	
17. INFORMANT <b>Jenieva E. Burroughs - wife - same item #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute Coronary Insufficiency</b> DUE TO (b) <b>Coronary Artery Heart Disease.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Rockville</b>	
22. DATE SIGNED <b>7-18-1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/21/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>		25a. REC'D BY REGISTRAR <b>JUL 21 1966</b>	
1331 Rockville Pike Rockville, Maryland		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10003

20073

7-13-1946

7-13-1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

CLEARANCE DR. BALL

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10076

CERTIFICATE OF DEATH

10068

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>11 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>OAKHAVEN CONVALESCENT HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WEST HYATTSVILLE</b> d. STREET ADDRESS <b>2708 KIRKWOOD PL</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOROTHY P CALLAN</b>		4. DATE OF DEATH Month Day Year <b>JULY 2 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 24, 1911</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV.</b>	9. AGE (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>JAMES D. CALLAN</b>		14. MOTHER'S MAIDEN NAME <b>SUE CUMBERLAND</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>XXXXXXXXXX</b>	
17. INFORMANT <b>SISTER XXXXX</b> Address <b>2505 Queens Chapel Rd Hyattsville, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC RHEUMATIC HEART</b> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DISEASE WITH MITRAL</b> DUE TO (c) <b>INSUFFICIENCY</b> INTERVAL BETWEEN ONSET AND DEATH <b>21 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> , to <b>7/2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>July 2</b> , 19 <b>66</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence A. Rapee</b>		22b. DATE SIGNED <b>7/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE RAPEE MD</b>		22d. ADDRESS <b>1732 EYE ST N.W. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 5, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>C. Glen Carter</b> <b>Warner E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judy</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judy</b>	

10067

10067

✓ 10067



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10077

## CERTIFICATE OF DEATH

10069

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN lb <b>20 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>						d. STREET ADDRESS <b>4709 BRADLEY BLVD.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA C. CARDER</b>		4. DATE OF DEATH <b>JULY 25 1966</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/1/32</b>		9. AGE (In years last birthday) yrs. <b>34</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Charles H. Croghan</b>						14. MOTHER'S MAIDEN NAME <b>Lillian L. Edwards</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Step-father</b> Address <b>Granville A. Edwards-Same Item #2</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis, laennec's</b> 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic Alcoholism</b> DUE TO (c) <b>-----</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1966</b> , to <b>July 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 25, 1966</b> , and that death occurred at <b>9:30 P.M.</b> , from causes and on the date stated above.													
22a. SIGNATURE <b>Gene U. Cohen</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>---</b>					
22c. PHYSICIAN'S NAME (Type) <b>GENE U. COHEN, M.D.</b>						22d. ADDRESS <b>1106 SPRING ST. SILVER SPRING, M.D.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/29/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>							
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>						ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

10001

CARDER

Charles H. Groghan

Unknown

NO

Graville, Barbara - age 12

Congressional Com.

1985, 1986

Robert A. Humphrey, Bethesda, Maryland

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>408 Blandford St Apt 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Carrier</u>		4. DATE OF DEATH <u>July 27 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1966</u>
9. AGE (In years, last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>17</u> Hours <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Birth Certificate</u>		13. FATHER'S NAME <u>Joseph Roland Carrier</u>	
14. MOTHER'S MAIDEN NAME <u>Marie Ghislaine Fortin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>7549</u>		17. INFORMANT <u>Birth Certificate</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> DUE TO (b) <u>congenital heart disease</u> (c) <u>aortic atresia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-24-66</u> to <u>7-27-66</u> , that (I) (we) last saw the deceased alive on <u>7-27-66</u> and that death occurred at <u>5:15</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>T. Herouet Zeiber</u>		22b. DATE SIGNED <u>7-27-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. HEROUET ZEIBER</u>		22d. ADDRESS <u>7602 Connecticut Ave Ch. Charles</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 29 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

6-223350



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10073

## CERTIFICATE OF DEATH

10071

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>Derwood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>16912 Baedwood Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>PHILIP</b> Middle <b>CHELEMER</b> Last <b>CHELEMER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Union Representative</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailors Union</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simon Chelemer</b>		14. MOTHER'S MAIDEN NAME <b>Pauline ? ? ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>335-10-0482</b>	
17. INFORMANT <b>Jack Chelemer</b>		Address <b>3725 Astoria Road Kensington, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>generalized arteriosclerosis</b> DUE TO <b>5 yrs</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>7/6</b> , 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>7/6</b> , 19 <b>66</b> , and that death occurred at <b>3 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Herbert Wechsler</b> M.D.		22b. DATE SIGNED <b>7/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert Wechsler</b>		22d. ADDRESS <b>1800 Eye St NW Wash D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-8-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattsville Md.</b>	
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		25a. REC'D BY REGISTRAR <b>4217 9th Street N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>JUL 12 1966</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001



# MARYLAND STATE DEPARTMENT OF HEALTH

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE  
HEALTH DEPT.**

10080

10072

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN ID <b>none</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gaithersburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>					
3. NAME OF DECEASED (Type or print) <b>Frederick Daniel Church</b>			4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/3/94</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>unknown</b>			12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		
17. INFORMANT <b>Elisa Church</b>			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute and chronic respiratory failure</b> <b>583X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>accompanied by Hepatic insufficiency</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>July 10, 1966</b>	
EXAMINER'S NAME (Type) <b>Belden R. Reap, M.D.</b>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/13/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
23d. LOCATION (City, town or county) <b>Arlington, Va.</b>		(State)			
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10081

CERTIFICATE OF DEATH

10073

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>15-1</u>		d. STREET ADDRESS <u>4628 Edgefield Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jeffrey Clifford Clappitt</u>		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-66</u>
9. AGE (In years lost birthday) yrs. <u>8</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montg. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John M. Clappitt</u>		14. MOTHER'S MAIDEN NAME <u>Jean Johncox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>father</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>7625</u> IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Immaturity.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Asphyxiation</u> (b) <u>Asphyxiation</u> (c) <u>Asphyxiation</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/10</u> , 19 <u>66</u> , to <u>7/10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/10</u> , 19 <u>66</u> , and that death occurred at <u>5:27</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>C. Francis Scallero</u>		22b. DATE SIGNED <u>7/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. Francis Scallero</u>		22d. ADDRESS <u>3547 Chesapeake St. NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-13-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Buitland, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

6 - 195990

10023

10081

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		1945		New York	
Cause of Death		Occupation		Education		Marital Status		Religion		Burial Place	
Heart Disease		Teacher		High School		Married		Catholic		Cemetery	
Date of Birth		Date of Death		Time of Death		Signature of Doctor		Signature of Registrar		Signature of Witness	
1900		1945		10:00 AM		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>				c. LENGTH OF STAY IN IB <b>??</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8404 Buckhannon Drive</b>					d. STREET ADDRESS <b>8404 Buckhannon Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence</b>			First <b>E.</b> Middle <b>Clausman</b>		Last <b></b>		4. DATE OF DEATH <b>7</b> Month <b>14</b> Day <b>19</b> Year <b>66</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 14, 1898</b>		9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>4</b> Days <b>0</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Cox</b>					14. MOTHER'S MAIDEN NAME <b>Mary McCafferty</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Daughter</b>		Address <b>Miss Ruth M. Clausman Same Item #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Adenocarcinoma of Colon</b> DUE TO (c) <b></b>								INTERVAL BETWEEN ONSET AND DEATH <b>few wks.</b> <b>15 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>65</b> , to <b>7/14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/11</b> , 19 <b>66</b> , and that death occurred at <b>8:30</b> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>G. Lennard Gold</b>						M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Lennard Gold, M.D.</b>						22d. ADDRESS <b>8641 Colesville Rd., Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<b>Bur-transit</b>		<b>7/14/1966</b>		<b>Gethsemane Cemetery</b>		<b>Reading Pennsylvania</b>			
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>					25a. REC'D BY REGISTRAR <b>JUL 18 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

10074

Montgomery

MARYLAND

Potomac

21

2 Potomac

8404 Potomac Drive

8404 Potomac Drive

Washington

Washington

Female White

USA

Massachusetts

Honolulu

Mary McGarity

Michael Cox

in later

Miss Ruth M. Chapman, same item as

unknown

NO

Testimonial Collection

Admission of Color

7/14/1956 Gethsemane Cemetery Reading Pennsylvania

Robert A. Humphrey Bethesda, Maryland

G. Leonard Gold, M.D.

8841 Colossus Rd., Silver Spring, MD



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10083

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10075

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAROMA PARK</i>		c. LENGTH OF STAY IN 1b <i>3 DAYS</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>WASH. SAN. &amp; HOSPITAL</i>		d. STREET ADDRESS <i>304 Longfellow St. N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>FRED ADAMS CLAYTON</i>		4. DATE OF DEATH Month <i>July</i> Day <i>5</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-29-40</i>
9. AGE (In years last birthday) yrs. <i>25</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>C&amp;P</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Phone Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HOWARD C. CLAYTON</i>		14. MOTHER'S MAIDEN NAME <i>MARIETTA ADAMS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>Yes ARMY</i>		16. SOCIAL SECURITY NO. <i>HOSP. RECORDS</i>	
17. INFORMANT <i>HOSP. RECORDS</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple, extreme, skull</i> DUE TO (b) <i>fractures with intracranial</i> DUE TO (c) <i>hemorrhage.</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18) <i>Deceased ran into street and was struck by auto</i>	
20c. TIME OF INJURY Month, Day, Year <i>2:20 p.m. 7-2 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Street</i>		20f. (City or town) (County) (State) <i>Hyattsville, D. Geo., Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELOEN R. REAP M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/7/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>	
24. FUNERAL DIRECTOR <i>The S. H. Hines Company-</i>		ADDRESS <i>Washington, DC</i>	
25a. REC'D BY REGISTRAR <i>JUL 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10075

10083

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "copy" and "copy" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10084					10076						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Montgomery</b> MARYLAND					a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>63 days</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>National Institute of Health Clinical Center</b>					d. STREET ADDRESS <b>Route #2, Box 169</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<b>Eather</b>		<b>Ruth</b>		<b>Clinkscale</b>		Month <b>July</b> Day <b>6</b> Year <b>1966</b>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>Female</b>		<b>Negro</b>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>13 October 1902</b>		<b>63</b> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<b>Teacher</b>				<b>Education</b>		<b>South Carolina</b>			<b>USA</b>		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
<b>Herod C. Clinkscale</b>						<b>Lessie Robinson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<b>No</b>				<b>---</b>		<b>249-60-4549</b>		<b>The Medical Records The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right lower lobe pulmonary infarction</b>										<b>5 days</b>	
DUE TO (b) <b>Mycosis fungoides</b>										<b>5 years</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19											
21. I certify that (this hospital) attended the deceased from <b>May 4</b> , 1966, to <b>July 6</b> , 1966, that (we) last saw the deceased alive on <b>July 6</b> , 1966, and that death occurred at <b>1:13M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Wm R. Levis</b>								P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>July 6, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William R. Levis, M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>				23b. DATE THEREOF <b>7-9-66</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <b>SENECA, So. CAR.</b>			
24. FUNERAL DIRECTOR <b>James C. Chinn Arlington, Va.</b>						25a. REC'D BY REGISTRAR DATE <b>JUL 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

William R. Davis, M.D.

Institute of Health, Bethesda, Maryland  
The Clinical Center, National  
July 6, 1966

July 6 1966

July 4

1:13  
P.M.

July 6

Myocardial infarction

Right lower lobe pulmonary infarction

42-60-4549

The Clinical Center, Bethesda, Maryland

The Medical Records

Leslie Robinson

Barry C. Clinkscale

Education

South Carolina

USA

Female Negro

13 October 1902

Race

Clinkscale

July

Route 42, Box 103

of days

Vienna

Virginia

Walter

Montgomery

Bethesda

00 00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>STATE OF MARYLAND</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN ID <b>182 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> d. STREET ADDRESS <b>91 Frost Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Albert</b> Middle <b>Cope</b> Last <b>Cook</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>13</b> Year <b>1966</b>						
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>14 August 1908</b>		<b>9. AGE</b> (In years last birthday) <b>57</b> yrs. IF UNDER 1 YEAR: Months <b>01</b> Days <b>2</b> IF UNDER 24 HRS.: Hours <b>00</b> Min. <b>00</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Dentist</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Dentistry</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>John G. Cook</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Myra Langford</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>216-38-1231</b>		<b>17. INFORMANT</b> <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Reticulum Cell Sarcoma generalized</b> (b) <b>2000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Renal Failure</b> <b>10 days</b>									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 Years</b>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that</b> <b>D</b> (this hospital) attended the deceased from <b>12 January, 1966</b> , to <b>13 July, 1966</b> , that <b>D</b> (we) last saw the deceased alive on <b>13 July 1966</b> , and that death occurred at <b>7:25 PM</b> from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>Ralph S. Blume</b>					<b>22b. DATE SIGNED</b> <b>14 July 1966</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Ralph S. Blume, MD</b>		
<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>7/17/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Frostburg, Memorial</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Frostburg Maryland</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Tyson Wheeler</b>					<b>25a. REC'D BY REGISTRAR</b> <b>JUL 20 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		

MEDICAL CERTIFICATION

10073

10082

Allegany

Maryland

Monocromy

Proctor

182 days

Bethesda

21 Front Avenue

The Clinical Center, Bethesda, Maryland

19 66

July

Book

Cope

Albert

14 August 1968 27

Wife

Male

U.S.A.

Maryland

Dentistry

Dentist

Hyattsville

John D. Cook

The Medical Records  
The Clinical Center, Bethesda, Maryland  
416-38-1231

Necklesham Cell Sarcoma generalized

3 Years

10 days

Recent Failure

66

19 July

66

14 January

66

13 July

7:25 PM

The Clinical Center, National  
Institutes of Health, Bethesda, Md.  
14 July 1968

Ralph S. Hume, MD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darnestown		c. LENGTH OF STAY IN b. 16		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darnestown - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Berryville Road						d. STREET ADDRESS Berryville Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDNA May COUNCIL						4. DATE OF DEATH July 20, 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH April 5, 1888		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days 5 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John M. Post						14. MOTHER'S MAIDEN NAME Rosetta Mixer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 223-18-4003		17. INFORMANT Margaret R. Austrera - Niece - same item #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral-vascular accident											
331X DUE TO (b) cerebral arteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetes mellitus											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington, Virginia		(County) Arlington		(State) Virginia	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1966 to July 20, 1966, that (I) (we) last saw the deceased alive on July 19, 1966, and that death occurred at 5 AM, from the causes and on the date stated above.											
22a. SIGNATURE John G. Fawcett M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 20 July 1966			
22c. PHYSICIAN'S NAME (Type) John G. Fawcett						22d. ADDRESS Dawsonville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/22/66		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City, town or county) Arlington, Virginia		(State) Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home Rockville, Maryland						25a. REC'D BY REGISTRAR JUL 22 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge			

MEDICAL CERTIFICATION

10058

THE STATE OF TEXAS

10058

NOTARY PUBLIC  
COUNTY OF \_\_\_\_\_  
STATE OF TEXAS  
My Commission Expires \_\_\_\_\_  
I, \_\_\_\_\_  
do hereby certify that \_\_\_\_\_  
has been duly elected \_\_\_\_\_  
of the \_\_\_\_\_  
precinct of \_\_\_\_\_  
County of \_\_\_\_\_  
State of Texas.

Items 15, 17 Film G379 8/19/66 mh

10087

## CERTIFICATE OF DEATH

10079

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>2041 Viers Mill Road.</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond A. Cunningham</u>		4. DATE OF DEATH <u>7</u> <u>25</u> <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3</u> <u>1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paint Representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Murphy Paint Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Henry G. Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>Yes</u> <u>None Unknown</u>		16. SOCIAL SECURITY NO. <u>137-01-0788</u>	
17. INFORMANT <u>Evelyn M. Cunningham</u>		Address <u>2041 Viers Mill Wheaton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO (b) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ OUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT</u> , 19 <u>65</u> , to <u>25 JULY</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>24 JULY</u> 19 <u>66</u> , and that death occurred at <u>11 P</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WALTER GOOZA MD</u>		22d. ADDRESS <u>2340 GLENMONT CIR WHEATON MD</u>	
23a. BURIAL-CREATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 29, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery, Troy, NEW YORK</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Warner E. Pumphrey, Inc.</u>		DATE <u>JUL 27 1966</u>	

437-9111

## CERTIFICATE OF DEATH

10080

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4112 Culver Street</b>		d. STREET ADDRESS <b>4112 Culver Street</b>	
3. NAME OF DECEASED (Type or print) <b>ROBERT GUYTON CURHAM</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1887</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Zealand</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert Curham</b>	
14. MOTHER'S MAIDEN NAME <b>Janet MacFarland</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>127-14-8548-A</b>		17. INFORMANT <b>Daughter</b> Address <b>Mrs. Walter Wien, 4112 Culver St, Kens, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBOSIS OR RUPTURE</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A.S.N.D.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>YEARS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY EMPHYSEMA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>13 JULY</b> , 19 <b>66</b> , to <b>26 JULY</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>21 JULY</b> , 19 <b>66</b> , and that death occurred at <b>12:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. Howard Yeager Jr</b>		22b. DATE SIGNED <b>7/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. HOWARD YEAGER JR</b>		22d. ADDRESS <b>1808 CONN AVE. N.W. WASH, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>	23b. DATE THEREOF <b>7/28/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Brooklyn New York</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25. REC'D BY REGISTRAR DATE <b>JUL 29 1966</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2800

10200

уменьшения

## References

4111 Colver Street

40948 2010 2111

1981, 22 oct.

Report Card

James MacFarlane

— 4 —

— 9428 —

*(Faint, illegible text)*

1704

УТВЕРЖДАЮ:

150133

1985-1986

Bethesda, Maryland

Yoshimasa, Hiroshi



10089

CERTIFICATE OF DEATH

10081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. &amp; Hosp.</u>		d. STREET ADDRESS <u>1009 Sterling Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>BURNHAM</u> Last <u>CURTIS, SR</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/7/88</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT OWNER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARION CURTIS</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Corbin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI - Army</u>		16. SOCIAL SECURITY NO. <u>579-48-5853</u>	
17. INFORMANT <u>Mrs. Dorothy Somerville</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5410 BLEEDING DUODENAL ULCER</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTEROSCLEROTIC VASCULAR DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>JULY 1963</u> to <u>JULY 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>JULY 17, 1966</u> , and that death occurred at <u>6:55 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert L. Krichmar</u>		22b. DATE SIGNED <u>7/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		22d. ADDRESS <u>7730 ALASKA AVENUE NW. WASHINGTON D.C. 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 20, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orleans Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Orleans, Va.</u>
24. FUNERAL DIRECTOR <u>C. E. Warner &amp; Sons, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 20 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10001

CENTRAL OF ILLINOIS

10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MONTGOMERY STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>804 Westmore</u>			c. LENGTH OF STAY IN 1b <u>135 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>804 Westmore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rochester, Md.</u>					d. STREET ADDRESS <u>Rochester, Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard E. Davis</u>					4. DATE OF DEATH <u>July 30 1966</u>		Day Year		
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-07 59</u>		9. AGE (In years last birthday) <u>59</u> yrs. FUNDER 1 YEAR <input type="checkbox"/> FUNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Davis</u>					14. MOTHER'S MAIDEN NAME <u>Mary Adams</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>807 Westmore, Rockville</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> 4201 DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 58</u> , to <u>7-30 66</u> , that (I) (we) last saw the deceased alive on <u>7-24 66</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Clive E. Jackson</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Clive E. Jackson</u>					22d. ADDRESS <u>202 Nantux, Rockville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>		
24. FUNERAL DIRECTOR <u>Robert L. Suoroden</u> ADDRESS <u>Rockville, Md.</u>					25a. REC'D BY REGISTRAR <u>AUG 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

10025

10000

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Bureau" and "Department" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1  
M  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 8 Film G378 7/20/66 mh

CERTIFICATE OF DEATH

10091		10083	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u> 16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. &amp; HOSP.</u>		d. STREET ADDRESS <u>4503 AMMENDALE RD</u>	
3. NAME OF DECEASED (Type or print) <u>ARLIE DAY</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888</u> <u>7-18-89</u>
9. AGE (In years, last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>12</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sand &amp; Gravel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>BENJAMIN ALEXANDER MORRISON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH FAUST</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 32 2988</u>	
17. INFORMANT <u>Hugh A. Day</u>		Address <u>4501 Ammendale Rd. Beltsville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>aspiration of gastric content</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-19-1966</u> to <u>7-12-1966</u> that (I) (we) last saw the deceased alive on <u>7-12-1966</u> and that death occurred at <u>230</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Clarence Coombs</u>		22b. DATE SIGNED <u>7-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLARENCE COOMBS</u>		22d. ADDRESS <u>831 UNIVERSITY BLVD EAST SIL SPG MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-15-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Hughesville Pa</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers &amp; Co. Riverdale Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

62901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10092

Item #11 & 12 prior taken from birthcert.

CERTIFICATE OF DEATH

10084

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>3333 University Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Deas</u> First Middle Last 4. DATE OF DEATH <u>July 2 1966</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 2, 1966</u> 9. AGE (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Mont. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter John Deas</u>		14. MOTHER'S MAIDEN NAME <u>Jean Marion Posser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>mother</u>	
17. INFORMANT <u>mother</u> <u>3333 University Blvd. West Kensington, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Foetal atelectasis</u> <u>7625</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Prematurity</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-2-66</u> , 19 <u>66</u> , to <u>7-2-66</u> , 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>7-2-66</u> , 19 <u>66</u> , and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>McClouey</u> M.D.		22b. DATE SIGNED <u>7-2-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>3716 Howard Ave, Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-5-66</u>		23b. DATE THEREOF <u>7-5-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City, town or county) (State) <u>BETHESDA, MD.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Amelia C. Carter Admin. (per 373)</u> ADDRESS <u>Suburban Hospital Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 13 1966</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6-223327

18001

18001

82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

(M)

CERTIFICATE OF DEATH

10085

1. PLACE OF DEATH COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>34RS. 28d.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> <b>DC.</b> b. COUNTY <b>MONT.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RESMOR - 5721 GROSVENOR LANE</b>		d. STREET ADDRESS <b>4700 CONNECTICUT AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KATHERINE J. DICKIE</b>		First Middle Lost <b>KATHERINE J. DICKIE</b>		4. DATE OF DEATH Month Day Year <b>JULY 4 1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 20 - 1880</b>		9. AGE (In years lost birthday) <b>85</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CONNECTICUT</b>	
13. FATHER'S NAME <b>JAMES HEALY</b>		14. MOTHER'S MAIDEN NAME <b>BRIDGET CHOATESSY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>J. THOMAS DICKEY - SON - 2032 - BELMONT RD. N.W. WASH. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis - Rthumphere</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>---</b>				INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardic Stenosis; genl. arteriosclerosis - Pericardial Anomalia</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>7/2</b> , 19 <b>66</b> , to <b>7/4</b> , 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>7/2</b> , 19 <b>66</b> , and that death occurred at <b>34 - M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E. Curtin</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Joseph Gawler's Sons, Inc.</b>		22d. ADDRESS <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-7-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>		24. FUNERAL DIRECTOR'S NAME (Type) <b>Joseph Gawler's Sons, Inc.</b>			
24a. ADDRESS <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



10094

## CERTIFICATE OF DEATH

10086

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montg.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville, 15-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>at home</i>		d. STREET ADDRESS <i>12800 Glen Mill Road</i>	
3. NAME OF DECEASED (Type or print) <i>Joseph Lee Dillard</i>		4. DATE OF DEATH <i>July 29 1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov-4-1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Auditor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Treasury Department</i>	9. AGE (In years last birthday) <i>94</i> yrs. IF UNDER 1 YEAR Months <i>8</i> Days <i>25</i> IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
11. BIRTHPLACE (County & State, or foreign country) <i>Stonefort, Illinois</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>William Lee Dillard</i>		14. MOTHER'S M maiden NAME <i>Mary Isabelle Adkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-36-3963</i>	
17. INFORMANT <i>Donna L. Dillard, 12800 Glen Mill Rd., Rockville, Md</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senile debility</i> DUE TO (b) <i></i> DUE TO (c) <i></i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1966</i> , to <i>July 29, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 28, 1966</i> , and that death occurred at <i>3:30 P.M.</i> from causes on and on the date stated above.			
22a. SIGNATURE <i>William C. Miller</i>		22b. DATE SIGNED <i>7-29-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		22d. ADDRESS <i>Brooke Ave, Gaithersburg, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>8-2-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	23d. LOCATION (City or Town) (County) (State) <i>Switzland Md</i>
24. FUNERAL DIRECTOR <i>Lee Funeral Home, Washington D.C.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>AUG 3 1966</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

Item 21 Film G378 7/20/66											
MONTGOMERY STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10095 CERTIFICATE OF DEATH 10087											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>36 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b> 16-2					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					d. STREET ADDRESS <b>1917 Fox Rox Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Margaret Ann Di Pasqua</b>			4. DATE OF DEATH <b>July 14 19 66</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 February 1945</b>		9. AGE (In years last birthday) <b>21</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>			
13. FATHER'S NAME <b>Patrick M. Sheedy</b>					14. MOTHER'S MAIDEN NAME <b>Mary Guare</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>577-62-8735</b> <b>Not Available</b>		17. INFORMANT Address <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 334x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Diffuse Cerebro Vascular Disease ?Vasculitis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 minutes</b> 1-2 Months											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hodgkins Disease 5 years</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8 June</b> , 19 <b>66</b> , to <b>14 July</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>14 July</b> , 19 <b>66</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Martin H. Cohen</b>					22b. DATE SIGNED <b>14 July 1966</b>						
22c. PHYSICIAN'S NAME (Type) <b>Martin H. Cohen, M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>7-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>				
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home, Inc., 7400 Georgia Ave. NW</b>					25a. REC'D BY REGISTRAR <b>JUL 19 1966</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

Prince Georges	Maryland	Monterey	Bethesda	30 Days	Adelphi
The Clinical Center, Bethesda, Maryland 1917 Fox Row Street					
66	14	July	M. Padua	Ann	Margaret
66	14	July	21 February 1945	White	Female
Ireland	Ireland	Patrick M. Shedy	Walter	White	Female
The Medical Records					
Not available The Clinical Center, Bethesda, Maryland					
Respiratory arrest					
Diffuse Cerebro Vascular Disease					
Hodgkins Disease 5 years					
66	14	July	8 June	66	14
The Clinical Center, National Institutes of Health, Bethesda, Md.					
Martin H. Cohen, M.D.					

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	
c. LENGTH OF STAY IN 1b <u>16-2</u>		d. STREET ADDRESS <u>2802 Laurel Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kathryn</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/1885</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alexander Hurd</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Lillian Galifaro</u>	
17. INFORMANT <u>Lillian Galifaro</u>		Address <u>2802 Laurel Ave. Cheverly, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		22. DATE SIGNED <u>7/13/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-16-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City, town or county) (State) <u>Bladensburg Rd. N.E.</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers, Riverdale, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>JUL 18 1966</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

10097

10089

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3207 Pickwick Lane</b>		d. STREET ADDRESS <b>3207 Pickwick Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>B.</b> Last <b>DIVVER, Sr.</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1900</b>
9. AGE (In years last birthday) yrs. <b>66</b>		IF UNDER 1 YEAR: Months <b>2</b> Days <b>29</b> Hours <b></b> Min. <b></b> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
11. BIRTHPLACE (State or foreign country) <b>Anderson, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Paul B. Divver</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Waller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>577-03-6237</b>	
17. INFORMANT <b>Mrs. Paul B. Divver, Wife-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma Liver</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Colon</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>7 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>66</b> , to <b>July</b> , 19 <b>66</b> that I lost the deceased alive on <b>July 25</b> , 19 <b>66</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James W. Egan</b>		ADDRESS (Street, city or town, state) <b>7720 Wisconsin Avenue</b> DATE SIGNED <b>JULY 27, 1966</b>	
PHYSICIAN'S NAME (Type) <b>James W. Egan, M.D.</b>		<b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/29/1966</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUL 29 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

20047

Montgomery

Montgomery

Chevy Chase

Chevy Chase

3207 Pickwick Lane

3207 Pickwick Lane

Paul

E.

DIVISION, ST.

JULY 29

24

White

Male

April 20, 1990

08

23

Automobile Dealer

Automobile

Anderson, South Carolina USA

Paul B. Driver

Pauline Waller

Will

Yes

677-03-8287 Mrs. Paul B. Driver, who same as home

7730 Wisconsin Avenue

Bethesda, Maryland

James W. Ryan, Jr.

7/29/1988

Arlington National Cem. Arlington

Virginia

Robert A. Humphrey Bethesda, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10098

Item 2 Film G378 7/15/66 mh

CERTIFICATE OF DEATH

10090

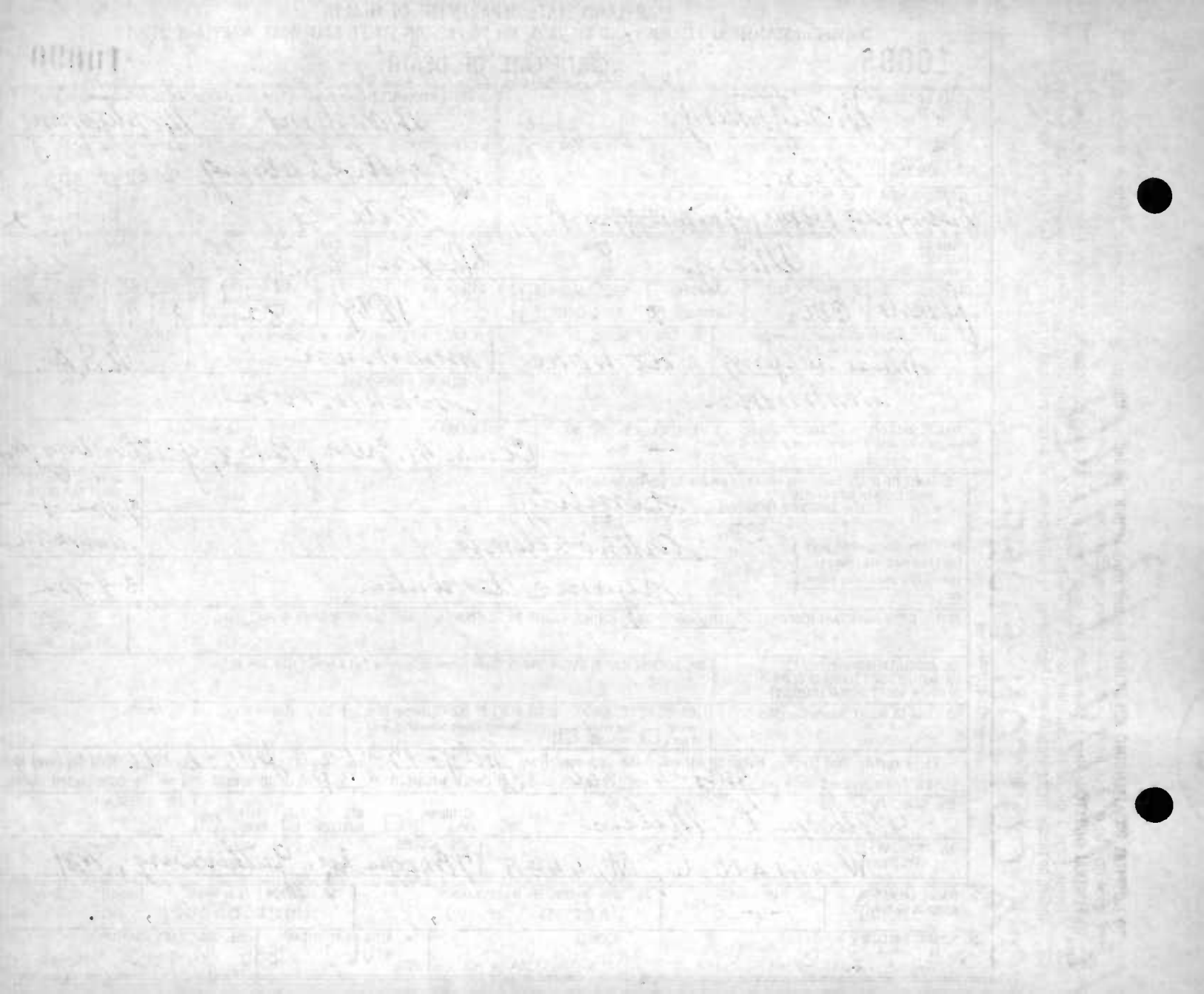
Item 1a Film G378 7/15/66 mh

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg Rural</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Nursing Home, Gaithersburg, Rtz 3</i>		d. STREET ADDRESS <i>Route 2 3</i>	
3. NAME OF DECEASED (Type or print) <i>Chary</i>		4. DATE OF DEATH <i>July 6, 1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house keeping</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>--</i>		16. SOCIAL SECURITY NO. <i>--</i>	
17. INFORMANT <i>Claude M. Green, Route 3, Gaithersburg, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senility</i> <i>4500</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>arteriosclerosis</i> DUE TO (c) <i>organic dementia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs +</i> <i>unknown</i> <i>3-4 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July - 12, 1962</i> to <i>July - 6, 1966</i> , that (I) (we) last saw the deceased alive on <i>July - 4 - 1966</i> , and that death occurred at <i>3 P.M.</i> on the date stated above.			
22a. SIGNATURE <i>William C. Miller</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		22d. ADDRESS <i>7 Brooks Ave., Gaithersburg, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>7-9-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Warren Chapel,</i>		23d. LOCATION (City or Town) (County) (State) <i>Martinsburg, Md.</i>	
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>Richville, Md</i>		DATE <i>JUL 13 1966</i>	

10000

10000

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>126 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b> d. STREET ADDRESS <b>2146 Elder Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Deborah Jean Doucette</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>July 19 1966</b>		<b>5. SEX</b> <b>Female</b>			<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>15 December 1956</b>			<b>9. AGE</b> (In years last birthday) <b>9 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>7 4</b>		<b>IF UNDER 24 HRS.</b> <b>4</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Delaware</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			<b>13. FATHER'S NAME</b> <b>Joseph L. Doucette</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>Philomena Ciarlo</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>None</b>			<b>17. INFORMANT</b> <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left hemorrhagic pneumonia and pleurisy</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Lipidosis-Nieman-Pick Variant</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 week</b> <b>6 years</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>					<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that</b> <b>X</b> (this hospital) attended the deceased from <b>15 March, 1966</b> , to <b>19 July, 1966</b> , that <b>X</b> (we) last saw the deceased alive on <b>19 July 1966</b> , and that death occurred at <b>8:03M</b> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <i>Robert I. Levy</i>					<b>22b. DATE SIGNED</b> <b>19 July 1966</b>			<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Robert I. Levy, M.D.</b>		<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>7-22-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>CATHEDRAL CEMETERY</b>			<b>23d. LOCATION</b> (City, town or county) (State) <b>WILMINGTON, DEL.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>ROBERT A. PUMPHREY</b>					<b>ADDRESS</b> <b>BETHESDA, MD.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUL 21 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles J. ...</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>803 Maple Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MABEL</b> First <b>R.</b> Middle <b>DOWNING</b> Last					4. DATE OF DEATH <b>July 7,</b> 19 <b>66</b> Month Day Year				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 7, 1893</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>T. L.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>FRANK BROSE</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-26-0329</b>		17. INFORMANT <b>Husband</b>		Address <b>above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1/24/1966</b> to <b>7/7/1966</b> , that (I) (we) last saw the deceased alive on <b>6/23/1966</b> , and that death occurred at <b>9:30</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert C. Macon</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/7/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Robert C. Macon</b>					22d. ADDRESS <b>809 Viers Mill Road, Rockville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home 1331 Rockville Pike Rockville, Maryland</b>					25a. REC'D BY REGISTRAR <b>JUL 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10002

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland

Rockville, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10101

CERTIFICATE OF DEATH

10093

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>South Arlington</b>	
c. LENGTH OF STAY IN Tb <b>9 Days</b>		d. STREET ADDRESS <b>3204 13th Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>May</b> Middle <b>Virginia</b> Last <b>DOWNS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 August 1907</b>
9. AGE (In years last birthday) yrs. <b>58</b>		10. IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>(Unknown) Henderson</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Brooks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-12-5677</b>	
17. INFORMANT <b>Roy J. Downs South Arlington, Virginia</b>		Address <b>3204 13th Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>0533</b> IMMEDIATE CAUSE (a) <b>Klebsiella Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>NO</del> (this hospital) attended the deceased from <b>30 June</b> , 19 <b>66</b> , to <b>8 July</b> , 19 <b>66</b> , that <del>NO</del> (we) last saw the deceased alive on <b>8 July</b> , 19 <b>66</b> , and that death occurred at <b>3:20 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Jack C. Zimmerman</b>		22b. DATE SIGNED <b>8 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jack C. Zimmerman LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/13/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington</b>	23d. LOCATION (City or Town) (County) (State) <b>Va.</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>JUL 14 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

MEDICAL CERTIFICATION

100001

UNITED STATES OF AMERICA

10101

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

DATE OF BIRTH TO DATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10094

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> D.C. & A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4857 Battery Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Donald G. Dudley</u> First Middle Last		4. DATE OF DEATH <u>7-15</u> Month Day Year 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11</u> 19 <u>1903</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Lawrence Dudley</u>		14. MOTHER'S MAIDEN NAME <u>Anna Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-12-4010</u>	
17. INFORMANT <u>Linda Ann Dudley, Wife</u>		Address <u>Same as #2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries Severe</u> DUE TO (b) <u>Fall from 5th floor of Apartment</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>978X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped out of window of 5th floor</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:40 am 7/15 19 66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Apt. Bldg</u>	20f. (City or town) (County) (State) <u>Bethesda Mont Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>7/15/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>7/18/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Wash., D. C.</u>		25a. REC'D BY REGISTRAR <u>JUL 20 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>

10001

80101

10001 80101 (10001) 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

10001 80101 10001 80101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
20M 1/65

MONTGOMERY STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10095									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b> 15-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>25906 Ridge Rd.</b>					d. STREET ADDRESS <b>25906 Ridge Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Resin</b>		Middle <b>F.</b>		Last <b>Duvall</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 14, 1884</b>		9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Nr. Damascus, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard L. Duvall</b>					14. MOTHER'S MAIDEN NAME <b>Mary Herrell</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-46-7098</b>		17. INFIRMANT <b>Deceased records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>was not</del> attended the deceased from <b>10/15</b> , 19 <b>65</b> to <b>7/5</b> , 19 <b>66</b> , that (I) <del>was</del> saw the deceased alive on <b>7/4</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>James P. Kerr, M.D.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>July, 6, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>					22d. ADDRESS <b>Damascus, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Damascus Meth.</b>		23d. LOCATION (City, town or county) (State) <b>Damascus, Md.</b>			
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>					25a. REC'D BY REGISTRAR <b>JUL 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005

10005



10104

CERTIFICATE OF DEATH

10096

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> c. LENGTH OF STAY IN lb <b>15 mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15-1 d. STREET ADDRESS <b>8201 16th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lena Esther Dworkin</b>		4. DATE OF DEATH Month Day Year <b>7 31 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/7/1882</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Hyman Laskovitz</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Minnie Tamarin</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no -</b>	
16. SOCIAL SECURITY NO. <b>578-52-5044</b>		17. INFORMANT <b>MORRIS DWORKIN</b> Address <b>7611 MAPLE AVE TAKOMA PK. M.D.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>260X</b> DUE TO <b>arteriosclerotic Cardio-Vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Alcoholic Myelitis</b> DUE TO (c) <b>Alcoholic Myelitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS.</b> <b>15 YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1951</b> , 19 to <b>7/31</b> , 19 <b>66</b> , that (I) ( <del>was</del> ) saw the deceased alive on <b>7/31</b> 19 <b>66</b> , and that death occurred at <b>8:55</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence J. Thomas</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/31/66</b>
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE J. THOMAS</b>		22d. ADDRESS <b>1712 EYE ST N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>8-2-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHEV SHOLOM</b>	23d. LOCATION (City or Town) (County) (State) <b>DC.</b>
24. FUNERAL DIRECTOR <b>Holberg F.H. 4217-9th St N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 3 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

UNIVERSITY OF MICHIGAN

10100

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10105

Item 23b Film G379 7/27/66 mh

CERTIFICATE OF DEATH

10097

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>6525 Landover Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>EASON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1966</b>
9. AGE (In years lost birthday) <b>— yrs.</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>1</b> Min <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Bethesda, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Claude E. Eason</b>		14. MOTHER'S MAIDEN NAME <b>Violet Toler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Mrs. Violet Eason, 6525 Landover Rd., Land-</b>		Address <b>over Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> DUE TO (b) <b>776 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>776 X</b> DUE TO (c) <b>776 X</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 14</b> , 19 <b>66</b> , to <b>July 14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>July 14</b> , 19 <b>66</b> , and that death occurred at <b>900A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>J. I. LUNCH</b>		22b. DATE SIGNED <b>15 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. I. LUNCH, M.D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>July 15, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lee Funeral Home</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>Hardesty Funeral Home, 12 Ridgely Ave, Annapolis Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

10003

10103

10103

U.S. DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D.C. 20315  
MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
BY: [Illegible]  
1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]  
6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]  
11. [Illegible]  
12. [Illegible]  
13. [Illegible]  
14. [Illegible]  
15. [Illegible]  
16. [Illegible]  
17. [Illegible]  
18. [Illegible]  
19. [Illegible]  
20. [Illegible]  
21. [Illegible]  
22. [Illegible]  
23. [Illegible]  
24. [Illegible]  
25. [Illegible]  
26. [Illegible]  
27. [Illegible]  
28. [Illegible]  
29. [Illegible]  
30. [Illegible]  
31. [Illegible]  
32. [Illegible]  
33. [Illegible]  
34. [Illegible]  
35. [Illegible]  
36. [Illegible]  
37. [Illegible]  
38. [Illegible]  
39. [Illegible]  
40. [Illegible]  
41. [Illegible]  
42. [Illegible]  
43. [Illegible]  
44. [Illegible]  
45. [Illegible]  
46. [Illegible]  
47. [Illegible]  
48. [Illegible]  
49. [Illegible]  
50. [Illegible]  
51. [Illegible]  
52. [Illegible]  
53. [Illegible]  
54. [Illegible]  
55. [Illegible]  
56. [Illegible]  
57. [Illegible]  
58. [Illegible]  
59. [Illegible]  
60. [Illegible]  
61. [Illegible]  
62. [Illegible]  
63. [Illegible]  
64. [Illegible]  
65. [Illegible]  
66. [Illegible]  
67. [Illegible]  
68. [Illegible]  
69. [Illegible]  
70. [Illegible]  
71. [Illegible]  
72. [Illegible]  
73. [Illegible]  
74. [Illegible]  
75. [Illegible]  
76. [Illegible]  
77. [Illegible]  
78. [Illegible]  
79. [Illegible]  
80. [Illegible]  
81. [Illegible]  
82. [Illegible]  
83. [Illegible]  
84. [Illegible]  
85. [Illegible]  
86. [Illegible]  
87. [Illegible]  
88. [Illegible]  
89. [Illegible]  
90. [Illegible]  
91. [Illegible]  
92. [Illegible]  
93. [Illegible]  
94. [Illegible]  
95. [Illegible]  
96. [Illegible]  
97. [Illegible]  
98. [Illegible]  
99. [Illegible]  
100. [Illegible]

CERTIFICATE OF DEATH

10106

10098

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Dist. of Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN IB <u>6 days</u>		d. STREET ADDRESS <u>3643 Brandywine Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J.</u> Last <u>Eckler</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1865</u>
9. AGE (In years lost birthday) <u>100</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman Young</u>		14. MOTHER'S MAIDEN NAME <u>Larry Huffnail</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>H. Ross Eckler</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X Uremia, acute with renal failure</u> DUE TO (b) <u>Nephrosclerosis, advanced</u> DUE TO (c) <u>Arteriosclerosis, generalised advanced</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days + one year + 10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Influenza, acute, moderately, severe</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 29, 1966</u> , to <u>July 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 29, 1966</u> , and that death occurred at <u>7:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp</u>		22b. DATE SIGNED <u>July 29 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp MD</u>		22d. ADDRESS <u>4740 Chevy Chase Dr 15 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>31 July 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Center</u>		23d. LOCATION (City or town) (County) (State) <u>Fort Plain, New York</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc, Washington, D. C.</u>		25. REC'D BY REGISTRAR <u>AUG 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000 1

2



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10107

## CERTIFICATE OF DEATH

10099

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph - Hiller Nursing Home</u>				d. STREET ADDRESS <u>9039 Silver Creek Parkway</u>			
3. NAME OF DECEASED (Type or print) <u>MRS. Freda Goodman Ezerzsky</u>				4. DATE OF DEATH <u>7 20 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/4/1905</u>	
9. AGE (In years last birthday) <u>60 yrs.</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u>		11. IF UNDER 24 HRS Hours <u>19</u> Min. <u>6</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Joseph Goodman</u>				14. MOTHER'S MAIDEN NAME <u>Serena Ecker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-14-8638</u>		17. INFORMANT <u>Mrs. Lida Rosa - Same as deceased</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with wide spread metastasis</u> DUE TO (c) <u>1960</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>July</u> , 19 <u>66</u> that (I) ( <u>we</u> ) lost saw the deceased alive on <u>19-July 1966</u> and that death occurred at <u>3:45 P</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Walter E. Goodman MD</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>20 July 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. GOODMAN MD</u>				22d. ADDRESS <u>2390 GLEMONT CIR WHEATON MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-24-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOME OF PEACE CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>LOS ANGELES, CALIFORNIA</u>	
24. FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons</u>				ADDRESS <u>3501-14th St. N. Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>W</u>	
				DATE <u>JUL 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12202

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10108

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10100

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>District of Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1 Beauford Road S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>Everett</u> Last <u>Fairbanks, Jr.</u>		4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/32</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Ray Everett Fairbanks, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Marjorie Jennings</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Dellinger Funeral Home, Woodstock, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple, extreme, internal</u> DUE TO (b) <u>injuries and fractured skull</u> DUE TO (c) <u>incurred when car overturned on road.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Deceased during phone call, 495, lost control of auto which overturned throwing him.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of this form). <u>Street Kensington Md.</u>		20c. TIME OF INJURY Month, Day, Year <u>8:12 p.m. 7-22-1966</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street Kensington Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 25, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedarwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Edinburg, Va.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>John B. Thomas</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>		DATE <u>JUL 25 1966</u>	

00101

00101

10103

## CERTIFICATE OF DEATH

10101

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Washington, D.C.</b> b. COUNTY <b>47-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>4/30/66 to 7/13/66</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>4808 - 8th Street, N.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Fallstick</b> Last <b>July</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/13</b>
9. AGE (In years last birthday) yrs. <b>52</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>13</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Library of Congress</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY FALLSTICK</b>		14. MOTHER'S MAIDEN NAME <b>UNK — REPERT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>5/12/34-5/25/47 UNKNOWN</b>	
17. INFORMANT <b>HOSP. RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1992</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Cystic infarct of midbrain</b> DUE TO (c) <b>Metastatic carcinoma</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Francis C. Mayle, M.D.</b>		22b. DATE SIGNED <b>7/13/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Francis C. Mayle, M.D.</b>		22d. ADDRESS <b>8218 Wisconsin Ave., Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>7/13/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ALLEN TOWN, PA.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL ADDRESS <b>FINALDI FUNERAL HOME 7400 GEORGIA AVE. N.W. WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>JUL 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

10101

10103

Washington, D.C.

WV 100

Bellevue Hospital

Bellevue Hospital

1908 - 8th Street, N.E.

July 11, 1908

WV 100

WV 100

Tommy's

History of

WV 100

1913-1914

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100

WV 100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10110

10102

1. PLACE OF DEATH a. CDUNTY <b>Montgomery</b> b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>15</b> d. NAME DF HDSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6900 Ridgewood Street</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>6900 Ridgewood Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME DF DECEASED (Type or print) First <b>E.</b> Middle <b>Emory</b> Last <b>Ferebee</b>				4. DATE DF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 66</b>							
5. SEX <b>Male</b>		6. CDOLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE DF BIRTH <b>11/14/1903</b>		9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b> Hours <b>1</b> Min. <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Govt. Administrator N. I. H.</b>				10b. KIND DF BUSINESS DR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Enoch D. Ferebee</b>				14. MOTHER'S MAIDEN NAME <b>Eva Love</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Shirley H. Ferebee</b>		Address <b>same as above</b>					
18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NONE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>11 YRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE DF DEATH (IF EITHER, IDENTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>							
20c. TIME DF INJURY Month, Day, Year Hour a.m. <b>11</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE DF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (b) (this hospital) attended the deceased from <b>7-18-66</b> , 19 <b>66</b> to <b>7-23</b> , 19 <b>66</b> that (we) last saw the deceased alive on <b>7-18-66</b> , and that death occurred at <b>130A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Charles U. Shilling</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-23-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles U. Shilling</b>						22d. ADDRESS <b>1830 Courser Court - McLean, Va.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>7/23/66</b>		23c. NAME DF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory Prince Georges Co. Md.</b>		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR <b>The S. H. Hines Company-Washington, DC</b>						25a. REC'D BY REGISTRAR <b>JUL 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>			

10102

10102

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10111

Item 16 Film G570 7/14/66 mh

10103

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u> c. LENGTH OF STAY IN 1b <u>5 MOS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Marylander Home of Rest, Inc.</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> d. STREET ADDRESS <u>1402 UNIVERSITY BLVD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sophie</u> First <u>Fisher</u> Middle Last <b>4. DATE OF DEATH</b> <u>July</u> Month <u>1</u> Day <u>1966</u> Year			<b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>W.</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-7-97</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years, last birthday) <u>68</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>Jacob Witt</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>E. SALAWAY</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>19-40-7045</u> <b>17. INFORMANT</b> <u>Debra Adams R.N. - Germantown, Md.</u> Address		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>4221</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		
<b>21. I certify</b> that (I) <u>(this hospital)</u> attended the deceased from <u>2/7/66</u> to <u>2/11/66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>6/30/66</u> , and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.			<b>22a. SIGNATURE</b> <u>James P. Kerr</u> M.D. <b>22b. DATE SIGNED</b> <u>7/11/66</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>JAMES P. KERR</u> <b>22d. ADDRESS</b> <u>26618 RIDGE RD. DAMASCUS MD.</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>7-3-1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>NAT'L MEM. PARK</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>FALLS CHURCH. VA.</u>			<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Goldberg Funeral Home - 4217 9th Ave.</u> ADDRESS <b>25a. REC'D BY REGISTRAR</b> <u>JUL 5 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		

MEDICAL CERTIFICATION

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10103

DEPARTMENT OF AGRICULTURE

1911

*[Faint, mostly illegible handwritten text, possibly a letter or report.]*

*[Faint, mostly illegible handwritten text at the bottom of the page.]*

CERTIFICATE OF DEATH

10112

10104

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8418 Queen Annes Drive		d. STREET ADDRESS 8418 Queen Annes Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Avis Deisher Flaherty		4. DATE OF DEATH Month Day Year July 3, 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1885
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas E. Deisher	
14. MOTHER'S MAIDEN NAME Eliza Wilhelm		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Silver Spring, Md. Florence Flaherty, 8418 Queen Annes Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterio sclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 to 7/2, 1966, that (I) (we) last saw the deceased alive on 6/27, 1966, and that death occurred at 6:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE Jack P. Segal M.D.		22b. DATE SIGNED 1966	
22c. PHYSICIAN'S NAME (Type) Jack P. Segal M.D.		22d. ADDRESS 5323 Conn. Ave NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 6, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Elbert	23d. LOCATION (City, town or county) (State) Eagle Rock, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE By: J. C. Gray -		25a. REC'D BY REGISTRAR JUL 6 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10104

10112

6418 Owen Avenue Drive

6418 Owen Avenue Drive

Robert E. Fisher

Robert E. Fisher

1907-1913

1907-1913

U.S.

Virginia

Robert E. Fisher

Robert E. Fisher

Robert E. Fisher

Robert E. Fisher

Robert E. Fisher

Robert E. Fisher

1907-1913

1907-1913

1907-1913



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2 Film G379 8/10/66 mh

10113

CERTIFICATE OF DEATH

10105

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>1 week</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>209 Lincoln St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nine Elizabeth Fleetwood</u>		4. DATE OF DEATH <u>July 27 1966</u>		5. AGE (In years last birthday) <u>82</u> yrs.	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>	
13. FATHER'S NAME <u>Henry Fleetwood</u>		14. MOTHER'S MAIDEN NAME <u>Emily Root</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records - Washington Sanitarium + Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Cancer of breast (metastases to lung)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>3-4 days</u> <u>5-6 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Varicose ulcers legs - malnutrition</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1965</u> , to <u>July 27, 1966</u> , that (I) (we) last saw the deceased alive on <u>7-27 1966</u> , and that death occurred at <u>12:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John R. Spencer</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-27-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u>		22d. ADDRESS <u>Burtonsville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Prince Geo. Co. Maryland</u>	
23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR <u>Arthur W. Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>JUL 29 1966</u>			

10105

10113

(1)

10114

## CERTIFICATE OF DEATH

10106

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15-1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>2222 Kansas Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ruby Merrile Foreman</u>		4. DATE OF DEATH <u>July 1</u> 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/9/1899</u> 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Dist. of Col.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Myrick</u>	
14. MOTHER'S MAIDEN NAME <u>Daphne Merrick</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Artlene Sparks</u> Address <u>900 French St. Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis Liver</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6-30</u> , 19 <u>66</u> , to <u>7-1</u> , 19 <u>66</u> that (I) <u>(we)</u> last saw the deceased alive on <u>7-1</u> , 19 <u>66</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen M.D.</u>		22b. DATE SIGNED <u>July 2, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Randall, Md. P.G. Maryland</u>
24. FUNERAL DIRECTOR <u>Hall Bros. Funeral Service</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>621 1/2 La. Ave. N.W. Washington D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

200 : 194

3420

FOR STATE  
HEALTH DEPT

10115

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10107

1. PLACE OF DEATH a. COUNTY <b>Mont.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6510-76th. St.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Mont. Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b> d. STREET ADDRESS <b>6510-76 th. Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Morley</b> Middle <b>Lewis</b> Last <b>Fyock</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1966</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1910</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>23</b>		IF UNDER 24 HRS. Hours <b>23</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>		11. BIRTHPLACE (State or foreign country) <b>Johnstown, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jerome Fyock</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Lewis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>David J. Fyock-Same as Item #2-Brother</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) <b>coronary arteriosclerosis with occlusion</b> DUE TO (c) <b>8 hrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Read, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>7-29-1966</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. READ, M.D.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/1/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
23d. LOCATION (City or Town) <b>Rockville</b>		23e. (County) <b>Maryland</b>		23f. (State)			
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





10116

## CERTIFICATE OF DEATH

10108

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>6 1/2 Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		15 - 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10616 Parkwood Drive</b>		d. STREET ADDRESS <b>10616 Parkwood Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANKIE</b> Middle <b>F.</b> Last <b>GAINES</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1886</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Levi C. Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Alice Baker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-8175</b>	
17. INFORMANT <b>Niece</b>		Address <b>Mrs. John Oldfield</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Cardiac Insufficiency</b> DUE TO (c) <b>Hepatic Cirrhosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>38 day</b> <b>Many yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/1</b> , 19 <b>66</b> , to <b>7/1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/1</b> , 19 <b>66</b> , and that death occurred at <b>7:15</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Bradley D. Hodgkins</b>		22b. DATE SIGNED <b>7/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>BRADLEY D. HODGKINS</b>		22d. ADDRESS <b>4413 Bradley Lane</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-6-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>JUL 7 1966</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ohio</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>142 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Youngstown</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>723 East Lucius Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Paul Joseph Gancarcik</b>		First Middle Last		4. DATE OF DEATH <b>July 20 1966</b>		Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>13 November 1919</b>		9. AGE (In years last birthday) <b>46</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Gancarcik</b>				14. MOTHER'S MAIDEN NAME <b>Mary Slavkosky</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1942 - 1946</b>		17. INFORMANT <b>The Medical Records</b> Address <b>The Clinical Center, Bethesda, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 2041 DUE TO (b) <b>Thrombocytopenia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>Blastic crisis of chronic myelogenous leukemia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>12 weeks</b> <b>12 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>28 February, 1966</b> , to <b>20 July, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>20 July 1966</b> , and that death occurred at <b>2:50M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>C. Kierney</b>		22b. DATE SIGNED <b>P.M. 20 July 1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>Carl E. Kierney, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>7-23-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Youngstown Ohio</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

Carl E. Hartley, M.D.

Institute of Health, Bethesda, Maryland  
The Clinical Center, National  
July 1950

July 1950

February 1950  
2:30  
P.M.

Plastic crisis of chronic myelogenous leukemia

Thrombocytopenia

Cerebral hemorrhage

Yes

1945 - 1946

44-70-0521

The Clinical Center, Bethesda, Maryland  
The Medical Records

George Geraschik

Mary Slavovskiy

Maintenance from

Maintenance

Tennessee

Male White 13 November 1919

Paul

Joseph

Geraschik

July

1950

The Clinical Center, Bethesda, Maryland

723 East Lucien Avenue

Bethesda

July 1950

Yonkers

Ohio

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10118

## CERTIFICATE OF DEATH

10110

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda - Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>4116 Leland Street</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES EARL GAPEN</u>		4. DATE OF DEATH <u>July 11 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1886</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Info. Specialist U.S. Dept. Agric.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Monroe, Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Levi Gapen</u>		14. MOTHER'S MAIDEN NAME <u>Frances Courtney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-66-8804</u>	
17. INFORMANT <u>Wife</u>		Address <u>Mrs. Ethelyn L. Gapen-Same as Item #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Orthostatic Pneumonia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemiplegia Left</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>3 hrs.</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 7</u> , 19 <u>66</u> to <u>July 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 10</u> , 19 <u>66</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Herman</u> M.D.		22b. DATE SIGNED <u>July 11, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Herman, M.D.</u>		22d. ADDRESS <u>4801 Montgomery Lane, Bethesda, Md 20814</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/14/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Mtg. Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
DATE <u>JUL 14 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

10110

EXHIBIT - OF DEATH

10110

Place Line  
80, 1108

7 2

Reflected Info. Specialist W. H. Wood, Monroe, La.

Foreign Country

Laos, Laos

878-88-8884 Mrs. Elizabeth J. Gagon - was as item 48

John J. Bernard, M.D.

878-88-8884 Mrs. Elizabeth J. Gagon - was as item 48

878-88-8884 Mrs. Elizabeth J. Gagon - was as item 48



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

10113

CERTIFICATE OF DEATH

10111

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		<u>15 - 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>1600 Springwood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>May Pomeroy Gibben</u>				4. DATE OF DEATH Month Day Year <u>July 17 1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-72</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willie Beecher Pomeroy</u>				14. MOTHER'S MAIDEN NAME <u>Fanny Gudgin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-48-2974</u>		17. INFORMANT <u>Records - Washington Sanitarium &amp; Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of dorsal spine</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary insufficiency - Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>62</u> , to <u>July 17, 1966</u> that (I) (we) lost saw the deceased alive on <u>July 17, 1966</u> , and that death occurred at <u>6:30 P.M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>Philip E. Jones</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones, M.D.</u>				22d. ADDRESS <u>800 Pershing Drive Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/20/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>The S. H. Hines Co. Washington, D. C.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10111

10111

RECEIVED OF DEPT.

RECEIVED

RECEIVED

THE S. H. BROS. CO. OF WASHINGTON, D. C.  
RECEIVED OF DEPT. OF AGRICULTURE  
JAN 1 1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10120					10112						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Montgomery MARYLAND					a. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital					d. STREET ADDRESS 12713 Laurie Drive						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First FREDERICK		Middle GOLDBERG		Last GOLDBERG		4. DATE OF DEATH Month 7 Day 20 Year 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/16		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Albert Goldberg					14. MOTHER'S MAIDEN NAME Fannie Glickfeld						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. WWII 579-10-7237		17. INFORMANT William Goldberg			Address 12713 Laurie Dr., Sil. Sp. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH From June 1966	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>left and right ventricular failure</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease with</u> DUE TO (c) <u>myocardial infarction</u>										3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1966</u> , to <u>July 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 19, 1966</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Aaron H. Traum</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 20 1966</u>			
22c. PHYSICIAN'S NAME (Type) Aaron H. Traum						22d. ADDRESS <u>8237 Georgia Ave Silver Spring, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 7/22/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION (City, town or county) (State) Arl., Va.			
24. FUNERAL DIRECTOR Bernard Danzansky & Sons						ADDRESS 3501-14th St., N.W., Wash.		25a. REC'D BY REGISTRAR DATE JUL 25 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

51101

51101

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental setup. It includes a list of the equipment used, the procedures followed, and the data collected. This part is essential for understanding the results of the study.

3. The third part of the report is a discussion of the results. It compares the findings with previous work in the field and discusses the implications of the results. It also mentions any limitations of the study and suggests areas for further research.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and states the overall conclusions. It also mentions any recommendations for future work.

5. The fifth part of the report is a list of references. It includes all the sources used in the study, such as books, articles, and other documents. This part is important for providing context and credit to the work of other researchers.

10121

## CERTIFICATE OF DEATH

10113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>7 dAs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>6904 20<sup>th</sup> AVENUE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jack Maurice Goldberg</u>		4. DATE OF DEATH Month Day Year <u>July 29 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRIVER - Diamond Cab Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAXI</u>	9. AGE (In years last birthday) yrs. <u>64</u>
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HERMAN GOLDBERG</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA KADER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-22-3231</u>	
17. INFORMANT <u>CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary artery atherosclerotic heart disease</u> DUE TO (b) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> to <u>July 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 28, 1966</u> , and that death occurred at <u>11<sup>45</sup> AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Frey</u>		22b. DATE SIGNED <u>7-29-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. FREY</u>		22d. ADDRESS <u>7105 Riggs Rd Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-31-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HAR ZION THEROTH ISRAEL CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>ROSEDALE MD</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>4217/92 HNR</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 2 1966</u>	

ELEGY

18161



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10122 Item #8 Film #4319 7/25/66 pc 10114  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>13 days + 4 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>2307 Dexter Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Norman Douglas Gooding</b>			4. DATE OF DEATH Month Day Year <b>July 15 1966</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1910</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veteran's Administration U.S. Gov't.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Herbert A. Gooding</b>				
14. MOTHER'S MAIDEN NAME <b>Hettie A. Fisher</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes U.S.A.F. WW2</b>				
16. SOCIAL SECURITY NO. <b>289-18-3689</b>			17. INFORMANT <b>Emily R. Gooding</b> Address <b>Hospital Record - Silver Spring, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure due to sepsis</b> <b>5720</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Peritonitis</b> DUE TO (c) <b>Regional ileitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary edema due to bronchial obstruction</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7 days</b>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>—</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>			
20f. (City or town) (County) (State) <b>—</b>		21. I certify that (I) (this hospital) attended the deceased from <b>July 3, 1966</b> , to <b>July 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 14, 1966</b> , and that death occurred at <b>1:11 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>James R. Goodson</b>			22b. DATE SIGNED <b>7/15/66</b>		22c. PHYSICIAN'S NAME (Type) <b>James R. Goodson</b>		
22d. ADDRESS <b>1746 K St. N.W. Washington D.C.</b>			22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 18, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			
23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		23e. FUNERAL DIRECTOR <b>C. Glen Carter</b>		23f. ADDRESS <b>434 Georgia Ave.</b>			
23g. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		23h. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		23i. DATE <b>JUL 19 1966</b>			

10110

STATE OF NEW YORK

1911

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10123

## CERTIFICATE OF DEATH

10115

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDNOR (RURAL)</b>		c. LENGTH OF STAY in lb <b>27 YRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1811 EDNOR ROAD</b>		d. STREET ADDRESS <b>1811 EDNOR ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>PAUL JACKSON GORE</b>		4. DATE OF DEATH <b>7 3 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/9/1895</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (County & State, or foreign country) <b>BROWNTOWN, VA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES GORE</b>	
14. MOTHER'S MAIDEN NAME <b>BETTY BEGERLY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>511-76-8800</b>		17. INFORMANT <b>WIFE</b> Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> 4201 <b>PARKINSON'S DISEASE</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>ARTERIO SCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>2 YRS</b> <b>YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>PULM. EMPHYSEMA; INANITION; ORGANIC BRAIN SYN.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1965</b> to <b>JULY 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>JUNE 30, 1966</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.	22a. SIGNATURE <b>Donald R. Lewis</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>7/3/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DONALD R. LEWIS M.D.</b>		22d. ADDRESS <b>700 CLOVERLY ST. SILVER SPR. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-5-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arman Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Burtonville Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Conneldean Land Md</b>		25a. REC'D BY REGISTRAR <b>JUL 7 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10115

10115

James G. Gore  
Wife: Mary  
Born: 1/1/1882  
Died: 1/1/1882  
Buried: 1/1/1882  
U.S.A.

James G. Gore  
Wife: Mary  
Born: 1/1/1882  
Died: 1/1/1882  
Buried: 1/1/1882  
U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10124					10116				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>4 yrs-5 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHERRY CHASE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>					d. STREET ADDRESS <u>4711-Morgan Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>Dallas</u> Last <u>Graham</u>			4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 10-1879</u>		9. AGE (in years, last birthday) <u>86</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dallas Johnson - M.D.</u>					14. MOTHER'S MAIDEN NAME <u>Letitia Latimer</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>			16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Charles R. Graham, Cherry Chase, Md.</u> Address <u>3410-Randolph Rd.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS, GENERALIZED</u> <u>4500</u> DUE TO (b) <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>-</u>									INTERVAL BETWEEN ONSET AND DEATH <u>10 YEARS</u> <u>2 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , <u>1962</u> , to <u>July 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>7-12</u> <u>1966</u> , and that death occurred at <u>2:30 M.</u> from the causes and on the date stated above.									22b. DATE SIGNED <u>7-25-66</u>
22a. SIGNATURE <u>Philip R. James</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <u>Philip R. James</u>					22d. ADDRESS <u>Washington Clinic - Misc. &amp; Western Ave., NW.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-27-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisconsin Ave. N.W. Wash. DC.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
					DATE <u>JUL 28 1966</u>				





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington State Hospital</b>		d. STREET ADDRESS <b>506 Chillum rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Bryan</b> Last <b>Griffiths</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-19-1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Typewriter Mechanic-U.S. Government</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Turin, N.Y.</b>	
11. BIRTHPLACE (State or foreign country) <b>US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Rev. Pugh Griffiths</b>		14. MOTHER'S MAIDEN NAME <b>Winifred Edmunds</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1st WW</b>		16. SOCIAL SECURITY NO. <b>220-54-0198</b>	
17. INFORMANT <b>Mrs. Virginia Griffiths</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary Artery Heart Disease</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Chapman</b> Address (Street, city, town, or county)	
22. DATE SIGNED <b>7/16/1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/19/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>The S. H. Hines Co. Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>JUL 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			

10113

1/10/1966

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10118

10126

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annandale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		d. STREET ADDRESS <b>6921 Pacific Lane</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ethel Sharp GRISWOLD</b>		4. DATE OF DEATH Month Day Year <b>July 8 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 June 1881</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Dakota Territory</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Sharp</b>		14. MOTHER'S MAIDEN NAME <b>Helen Elizabeth Rice</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Elizabeth G. Miller</b>		Address <b>6912 Pacific Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hepatitis with focal hepatic necrosis and granuloma, etiology undetermined.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5 July</b> , 19 <b>66</b> , to <b>8 July</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8 July</b> , 19 <b>66</b> , and that death occurred at <b>2:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>P. Blanchard</i>		22b. DATE SIGNED <b>8 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>P. BLANCHARD LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/12/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Arlington Va</b>
24. FUNERAL DIRECTOR <b>Everly-Wheatley Funeral Home</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS <b>1500 W. Braddock Road</b>		DATE <b>JUL 11 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11111

STATE OF OHIO

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10127 CERTIFICATE OF DEATH 10119

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>17027 Redland Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> d. STREET ADDRESS <b>17027 Redland Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DAVID R. GROGAN</b>		4. DATE OF DEATH <b>July 11, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/1915</b>
9. AGE (In years last birthday) <b>50</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William D. Grogan</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>577092012</b>	
17. INFORMANT <b>Army WWII</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO (b) <b>Coronary Artery Disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>11 July 66</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombophlebitis - Pulmonary Embolus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>50</b> , to <b>11 July</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9 July 66</b> , and that death occurred at <b>6A</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Wm. S. Murphy</b>	
22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Wm. S. Murphy</b>	
22d. ADDRESS <b>615 W. Montg. Ave., Rockville, Md.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/14/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Lutheran Church</b>		23d. LOCATION (City, town or county) (State) <b>Derwood, Montgomery, Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUL 13 1966</b>	
ADDRESS <b>1331 Rockville Pike, Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

10117

Condensation

Merchand

Californian

17027 Redland Road

July 11, 1944

20

Answers

COGNAC

Stacey Stone

William D. Hogan

TO: JESSIE

*Barney Hogan*

*Barney Hogan*

*Thank you for the information*

615 W. Monte Ave., Berkeley, 10.

Mr. J. Murphy

17027 Redland Road

July 10 1944



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

closed to Dr. Kasper's vault

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10128					10120						
Items 23c, 23d, 23e, 23f, 23g, 23h, 23i, 23j, 23k, 23l, 23m, 23n, 23o, 23p, 23q, 23r, 23s, 23t, 23u, 23v, 23w, 23x, 23y, 23z, 24a, 24b, 24c, 24d, 24e, 24f, 24g, 24h, 24i, 24j, 24k, 24l, 24m, 24n, 24o, 24p, 24q, 24r, 24s, 24t, 24u, 24v, 24w, 24x, 24y, 24z, 25a, 25b, 25c, 25d, 25e, 25f, 25g, 25h, 25i, 25j, 25k, 25l, 25m, 25n, 25o, 25p, 25q, 25r, 25s, 25t, 25u, 25v, 25w, 25x, 25y, 25z, 26a, 26b, 26c, 26d, 26e, 26f, 26g, 26h, 26i, 26j, 26k, 26l, 26m, 26n, 26o, 26p, 26q, 26r, 26s, 26t, 26u, 26v, 26w, 26x, 26y, 26z, 27a, 27b, 27c, 27d, 27e, 27f, 27g, 27h, 27i, 27j, 27k, 27l, 27m, 27n, 27o, 27p, 27q, 27r, 27s, 27t, 27u, 27v, 27w, 27x, 27y, 27z, 28a, 28b, 28c, 28d, 28e, 28f, 28g, 28h, 28i, 28j, 28k, 28l, 28m, 28n, 28o, 28p, 28q, 28r, 28s, 28t, 28u, 28v, 28w, 28x, 28y, 28z, 29a, 29b, 29c, 29d, 29e, 29f, 29g, 29h, 29i, 29j, 29k, 29l, 29m, 29n, 29o, 29p, 29q, 29r, 29s, 29t, 29u, 29v, 29w, 29x, 29y, 29z, 30a, 30b, 30c, 30d, 30e, 30f, 30g, 30h, 30i, 30j, 30k, 30l, 30m, 30n, 30o, 30p, 30q, 30r, 30s, 30t, 30u, 30v, 30w, 30x, 30y, 30z, 31a, 31b, 31c, 31d, 31e, 31f, 31g, 31h, 31i, 31j, 31k, 31l, 31m, 31n, 31o, 31p, 31q, 31r, 31s, 31t, 31u, 31v, 31w, 31x, 31y, 31z, 32a, 32b, 32c, 32d, 32e, 32f, 32g, 32h, 32i, 32j, 32k, 32l, 32m, 32n, 32o, 32p, 32q, 32r, 32s, 32t, 32u, 32v, 32w, 32x, 32y, 32z, 33a, 33b, 33c, 33d, 33e, 33f, 33g, 33h, 33i, 33j, 33k, 33l, 33m, 33n, 33o, 33p, 33q, 33r, 33s, 33t, 33u, 33v, 33w, 33x, 33y, 33z, 34a, 34b, 34c, 34d, 34e, 34f, 34g, 34h, 34i, 34j, 34k, 34l, 34m, 34n, 34o, 34p, 34q, 34r, 34s, 34t, 34u, 34v, 34w, 34x, 34y, 34z, 35a, 35b, 35c, 35d, 35e, 35f, 35g, 35h, 35i, 35j, 35k, 35l, 35m, 35n, 35o, 35p, 35q, 35r, 35s, 35t, 35u, 35v, 35w, 35x, 35y, 35z, 36a, 36b, 36c, 36d, 36e, 36f, 36g, 36h, 36i, 36j, 36k, 36l, 36m, 36n, 36o, 36p, 36q, 36r, 36s, 36t, 36u, 36v, 36w, 36x, 36y, 36z, 37a, 37b, 37c, 37d, 37e, 37f, 37g, 37h, 37i, 37j, 37k, 37l, 37m, 37n, 37o, 37p, 37q, 37r, 37s, 37t, 37u, 37v, 37w, 37x, 37y, 37z, 38a, 38b, 38c, 38d, 38e, 38f, 38g, 38h, 38i, 38j, 38k, 38l, 38m, 38n, 38o, 38p, 38q, 38r, 38s, 38t, 38u, 38v, 38w, 38x, 38y, 38z, 39a, 39b, 39c, 39d, 39e, 39f, 39g, 39h, 39i, 39j, 39k, 39l, 39m, 39n, 39o, 39p, 39q, 39r, 39s, 39t, 39u, 39v, 39w, 39x, 39y, 39z, 40a, 40b, 40c, 40d, 40e, 40f, 40g, 40h, 40i, 40j, 40k, 40l, 40m, 40n, 40o, 40p, 40q, 40r, 40s, 40t, 40u, 40v, 40w, 40x, 40y, 40z, 41a, 41b, 41c, 41d, 41e, 41f, 41g, 41h, 41i, 41j, 41k, 41l, 41m, 41n, 41o, 41p, 41q, 41r, 41s, 41t, 41u, 41v, 41w, 41x, 41y, 41z, 42a, 42b, 42c, 42d, 42e, 42f, 42g, 42h, 42i, 42j, 42k, 42l, 42m, 42n, 42o, 42p, 42q, 42r, 42s, 42t, 42u, 42v, 42w, 42x, 42y, 42z, 43a, 43b, 43c, 43d, 43e, 43f, 43g, 43h, 43i, 43j, 43k, 43l, 43m, 43n, 43o, 43p, 43q, 43r, 43s, 43t, 43u, 43v, 43w, 43x, 43y, 43z, 44a, 44b, 44c, 44d, 44e, 44f, 44g, 44h, 44i, 44j, 44k, 44l, 44m, 44n, 44o, 44p, 44q, 44r, 44s, 44t, 44u, 44v, 44w, 44x, 44y, 44z, 45a, 45b, 45c, 45d, 45e, 45f, 45g, 45h, 45i, 45j, 45k, 45l, 45m, 45n, 45o, 45p, 45q, 45r, 45s, 45t, 45u, 45v, 45w, 45x, 45y, 45z, 46a, 46b, 46c, 46d, 46e, 46f, 46g, 46h, 46i, 46j, 46k, 46l, 46m, 46n, 46o, 46p, 46q, 46r, 46s, 46t, 46u, 46v, 46w, 46x, 46y, 46z, 47a, 47b, 47c, 47d, 47e, 47f, 47g, 47h, 47i, 47j, 47k, 47l, 47m, 47n, 47o, 47p, 47q, 47r, 47s, 47t, 47u, 47v, 47w, 47x, 47y, 47z, 48a, 48b, 48c, 48d, 48e, 48f, 48g, 48h, 48i, 48j, 48k, 48l, 48m, 48n, 48o, 48p, 48q, 48r, 48s, 48t, 48u, 48v, 48w, 48x, 48y, 48z, 49a, 49b, 49c, 49d, 49e, 49f, 49g, 49h, 49i, 49j, 49k, 49l, 49m, 49n, 49o, 49p, 49q, 49r, 49s, 49t, 49u, 49v, 49w, 49x, 49y, 49z, 50a, 50b, 50c, 50d, 50e, 50f, 50g, 50h, 50i, 50j, 50k, 50l, 50m, 50n, 50o, 50p, 50q, 50r, 50s, 50t, 50u, 50v, 50w, 50x, 50y, 50z, 51a, 51b, 51c, 51d, 51e, 51f, 51g, 51h, 51i, 51j, 51k, 51l, 51m, 51n, 51o, 51p, 51q, 51r, 51s, 51t, 51u, 51v, 51w, 51x, 51y, 51z, 52a, 52b, 52c, 52d, 52e, 52f, 52g, 52h, 52i, 52j, 52k, 52l, 52m, 52n, 52o, 52p, 52q, 52r, 52s, 52t, 52u, 52v, 52w, 52x, 52y, 52z, 53a, 53b, 53c, 53d, 53e, 53f, 53g, 53h, 53i, 53j, 53k, 53l, 53m, 53n, 53o, 53p, 53q, 53r, 53s, 53t, 53u, 53v, 53w, 53x, 53y, 53z, 54a, 54b, 54c, 54d, 54e, 54f, 54g, 54h, 54i, 54j, 54k, 54l, 54m, 54n, 54o, 54p, 54q, 54r, 54s, 54t, 54u, 54v, 54w, 54x, 54y, 54z, 55a, 55b, 55c, 55d, 55e, 55f, 55g, 55h, 55i, 55j, 55k, 55l, 55m, 55n, 55o, 55p, 55q, 55r, 55s, 55t, 55u, 55v, 55w, 55x, 55y, 55z, 56a, 56b, 56c, 56d, 56e, 56f, 56g, 56h, 56i, 56j, 56k, 56l, 56m, 56n, 56o, 56p, 56q, 56r, 56s, 56t, 56u, 56v, 56w, 56x, 56y, 56z, 57a, 57b, 57c, 57d, 57e, 57f, 57g, 57h, 57i, 57j, 57k, 57l, 57m, 57n, 57o, 57p, 57q, 57r, 57s, 57t, 57u, 57v, 57w, 57x, 57y, 57z, 58a, 58b, 58c, 58d, 58e, 58f, 58g, 58h, 58i, 58j, 58k, 58l, 58m, 58n, 58o, 58p, 58q, 58r, 58s, 58t, 58u, 58v, 58w, 58x, 58y, 58z, 59a, 59b, 59c, 59d, 59e, 59f, 59g, 59h, 59i, 59j, 59k, 59l, 59m, 59n, 59o, 59p, 59q, 59r, 59s, 59t, 59u, 59v, 59w, 59x, 59y, 59z, 60a, 60b, 60c, 60d, 60e, 60f, 60g, 60h, 60i, 60j, 60k, 60l, 60m, 60n, 60o, 60p, 60q, 60r, 60s, 60t, 60u, 60v, 60w, 60x, 60y, 60z, 61a, 61b, 61c, 61d, 61e, 61f, 61g, 61h, 61i, 61j, 61k, 61l, 61m, 61n, 61o, 61p, 61q, 61r, 61s, 61t, 61u, 61v, 61w, 61x, 61y, 61z, 62a, 62b, 62c, 62d, 62e, 62f, 62g, 62h, 62i, 62j, 62k, 62l, 62m, 62n, 62o, 62p, 62q, 62r, 62s, 62t, 62u, 62v, 62w, 62x, 62y, 62z, 63a, 63b, 63c, 63d, 63e, 63f, 63g, 63h, 63i, 63j, 63k, 63l, 63m, 63n, 63o, 63p, 63q, 63r, 63s, 63t, 63u, 63v, 63w, 63x, 63y, 63z, 64a, 64b, 64c, 64d, 64e, 64f, 64g, 64h, 64i, 64j, 64k, 64l, 64m, 64n, 64o, 64p, 64q, 64r, 64s, 64t, 64u, 64v, 64w, 64x, 64y, 64z, 65a, 65b, 65c, 65d, 65e, 65f, 65g, 65h, 65i, 65j, 65k, 65l, 65m, 65n, 65o, 65p, 65q, 65r, 65s, 65t, 65u, 65v, 65w, 65x, 65y, 65z, 66a, 66b, 66c, 66d, 66e, 66f, 66g, 66h, 66i, 66j, 66k, 66l, 66m, 66n, 66o, 66p, 66q, 66r, 66s, 66t, 66u, 66v, 66w, 66x, 66y, 66z, 67a, 67b, 67c, 67d, 67e, 67f, 67g, 67h, 67i, 67j, 67k, 67l, 67m, 67n, 67o, 67p, 67q, 67r, 67s, 67t, 67u, 67v, 67w, 67x, 67y, 67z, 68a, 68b, 68c, 68d, 68e, 68f, 68g, 68h, 68i, 68j, 68k, 68l, 68m, 68n, 68o, 68p, 68q, 68r, 68s, 68t, 68u, 68v, 68w, 68x, 68y, 68z, 69a, 69b, 69c, 69d, 69e, 69f, 69g, 69h, 69i, 69j, 69k, 69l, 69m, 69n, 69o, 69p, 69q, 69r, 69s, 69t, 69u, 69v, 69w, 69x, 69y, 69z, 70a, 70b, 70c, 70d, 70e, 70f, 70g, 70h, 70i, 70j, 70k, 70l, 70m, 70n, 70o, 70p, 70q, 70r, 70s, 70t, 70u, 70v, 70w, 70x, 70y, 70z, 71a, 71b, 71c, 71d, 71e, 71f, 71g, 71h, 71i, 71j, 71k, 71l, 71m, 71n, 71o, 71p, 71q, 71r, 71s, 71t, 71u, 71v, 71w, 71x, 71y, 71z, 72a, 72b, 72c, 72d, 72e, 72f, 72g, 72h, 72i, 72j, 72k, 72l, 72m, 72n, 72o, 72p, 72q, 72r, 72s, 72t, 72u, 72v, 72w, 72x, 72y, 72z, 73a, 73b, 73c, 73d, 73e, 73f, 73g, 73h, 73i, 73j, 73k, 73l, 73m, 73n, 73o, 73p, 73q, 73r, 73s, 73t, 73u, 73v, 73w, 73x, 73y, 73z, 74a, 74b, 74c, 74d, 74e, 74f, 74g, 74h, 74i, 74j, 74k, 74l, 74m, 74n, 74o, 74p, 74q, 74r, 74s, 74t, 74u, 74v, 74w, 74x, 74y, 74z, 75a, 75b, 75c, 75d, 75e, 75f, 75g, 75h, 75i, 75j, 75k, 75l, 75m, 75n, 75o, 75p, 75q, 75r, 75s, 75t, 75u, 75v, 75w, 75x, 75y, 75z, 76a, 76b, 76c, 76d, 76e, 76f, 76g, 76h, 76i, 76j, 76k, 76l, 76m, 76n, 76o, 76p, 76q, 76r, 76s, 76t, 76u, 76v, 76w, 76x, 76y, 76z, 77a, 77b, 77c, 77d, 77e, 77f, 77g, 77h, 77i, 77j, 77k, 77l, 77m, 77n, 77o, 77p, 77q, 77r, 77s, 77t, 77u, 77v, 77w, 77x, 77y, 77z, 78a, 78b, 78c, 78d, 78e, 78f, 78g, 78h, 78i, 78j, 78k, 78l, 78m, 78n, 78o, 78p, 78q, 78r, 78s, 78t, 78u, 78v, 78w, 78x, 78y, 78z, 79a, 79b, 79c, 79d, 79e, 79f, 79g, 79h, 79i, 79j, 79k, 79l, 79m, 79n, 79o, 79p, 79q, 79r, 79s, 79t, 79u, 79v, 79w, 79x, 79y, 79z, 80a, 80b, 80c, 80d, 80e, 80f, 80g, 80h, 80i, 80j, 80k, 80l, 80m, 80n, 80o, 80p, 80q, 80r, 80s, 80t, 80u, 80v, 80w, 80x, 80y, 80z, 81a, 81b, 81c, 81d, 81e, 81f, 81g, 81h, 81i, 81j, 81k, 81l, 81m, 81n, 81o, 81p, 81q, 81r, 81s, 81t, 81u, 81v, 81w, 81x, 81y, 81z, 82a, 82b, 82c, 82d, 82e, 82f, 82g, 82h, 82i, 82j, 82k, 82l, 82m, 82n, 82o, 82p, 82q, 82r, 82s, 82t, 82u, 82v, 82w, 82x, 82y, 82z, 83a, 83b, 83c, 83d, 83e, 83f, 83g, 83h, 83i, 83j, 83k, 83l, 83m, 83n, 83o, 83p, 83q, 83r, 83s, 83t, 83u, 83v, 83w, 83x, 83y, 83z, 84a, 84b, 84c, 84d, 84e, 84f, 84g, 84h, 84i, 84j, 84k, 84l, 84m, 84n, 84o, 84p, 84q, 84r, 84s, 84t, 84u, 84v, 84w, 84x, 84y, 84z, 85a, 85b, 85c, 85d, 85e, 85f, 85g, 85h, 85i, 85j, 85k, 85l, 85m, 85n, 85o, 85p, 85q, 85r, 85s, 85t, 85u, 85v, 85w, 85x, 85y, 85z, 86a, 86b, 86c, 86d, 86e, 86f, 86g, 86h, 86i, 86j, 86k, 86l, 86m, 86n, 86o, 86p, 86q, 86r, 86s, 86t, 86u, 86v, 86w, 86x, 86y, 86z, 87a, 87b, 87c, 87d, 87e, 87f, 87g, 87h, 87i, 87j, 87k, 87l, 87m, 87n, 87o, 87p, 87q, 87r, 87s, 87t, 87u, 87v, 87w, 87x, 87y, 87z, 88a, 88b, 88c, 88d, 88e, 88f, 88g, 88h, 88i, 88j, 88k, 88l, 88m, 88n, 88o, 88p, 88q, 88r, 88s, 88t, 88u, 88v, 88w, 88x, 88y, 88z, 89a, 89b, 89c, 89d, 89e, 89f, 89g, 89h, 89i, 89j, 89k, 89l, 89m, 89n, 89o, 89p, 89q, 89r, 89s, 89t, 89u, 89v, 89w, 89x, 89y, 89z, 90a, 90b, 90c, 90d, 90e, 90f, 90g, 90h, 90i, 90j, 90k, 90l, 90m, 90n, 90o, 90p, 90q, 90r, 90s, 90t, 90u, 90v, 90w, 90x, 90y, 90z, 91a, 91b, 91c, 91d, 91e, 91f, 91g, 91h, 91i, 91j, 91k, 91l, 91m, 91n, 91o, 91p, 91q, 91r, 91s, 91t, 91u, 91v, 91w, 91x, 91y, 91z, 92a, 92b, 92c, 92d, 92e, 92f, 92g, 92h, 92i, 92j, 92k, 92l, 92m, 92n, 92o, 92p, 92q, 92r, 92s, 92t, 92u, 92v, 92w, 92x, 92y, 92z, 93a, 93b, 93c, 93d, 93e, 93f, 93g, 93h, 93i, 93j, 93k, 93l, 93m, 93n, 93o, 93p, 93q, 93r, 93s, 93t, 93u, 93v, 93w, 93x, 93y, 93z, 94a, 94b, 94c, 94d, 94e, 94f, 94g, 94h, 94i, 94j, 94k, 94l, 94m, 94n, 94o, 94p, 94q, 94r, 94s, 94t, 94u, 94v, 94w, 94x, 94y, 94z, 95a, 95b, 95c, 95d, 95e, 95f, 95g, 95h, 95i, 95j, 95k, 95l, 95m, 95n, 95o, 95p, 95q, 95r, 95s, 95t, 95u, 95v, 95w, 95x, 95y, 95z, 96a, 96b, 96c, 96d, 96e, 96f, 96g, 96h, 96i, 96j, 96k, 96l, 96m, 96n, 96o, 96p, 96q, 96r, 96s, 96t, 96u, 96v, 96w, 96x, 96y, 96z, 97a, 97b, 97c, 97d, 97e, 97f, 97g, 97h, 97i, 97j, 97k, 97l, 97m, 97n, 97o, 97p, 97q, 97r, 97s, 97t, 97u, 97v, 97w, 97x, 97y, 97z, 98a, 98b, 98c, 98d, 98e, 98f, 98g, 98h, 98i, 98j, 98k, 98l, 98m, 98n, 98o, 98p, 98q, 98r, 98s, 98t, 98u, 98v, 98w, 98x, 98y, 98z, 99a, 99b, 99c, 99d, 99e, 99f, 99g, 99h, 99i, 99j, 99k, 99l, 99m, 99n, 99o, 99p, 99q, 99r, 99s, 99t, 99u, 99v, 99w, 99x, 99y, 99z, 100a, 100b, 100c, 100d, 100e, 100f, 100g, 100h, 100i, 100j, 100k, 100l, 100m, 100n, 100o, 100p, 100q, 100r, 100s, 100t, 100u, 100v, 100w, 100x, 100y, 100z											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>					c. LENGTH OF STAY IN 1b <b>6 YEARS</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>					e. STREET ADDRESS <b>8510 16th ST.</b>						
3. NAME OF DECEASED (Type or print) First <b>ARNOLD</b> Middle <b>GROOBMAN</b> Last <b>GROOBMAN</b>					4. DATE OF DEATH Month <b>7</b> Day <b>10</b> Year <b>1966</b>						
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-15-13</b>		9. AGE (in years last birthday) <b>52 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONES</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>SAMUEL GROOBMAN</b>					14. MOTHER'S MAIDEN NAME <b>LEAH SPECTOR</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO. <b>154-12-8718</b>		17. INFORMANT <b>HOSP RECORDS</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>ARTERIOSCLEROSIS</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 <b>7-10</b> , 19 <b>66</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>7-10</b> 19 <b>66</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert Kramer</b>					22b. DATE SIGNED <b>7-10-66</b>						
22c. PHYSICIAN'S NAME (Type) <b>ROBERT KRAMER</b>					22d. ADDRESS <b>8484 16th ST. SS. MD</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BUCIAL</b>					23b. DATE THEREOF <b>7-12-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Pleasant Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>PHILADELPHIA N.J. PA</b>		
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>					25a. REC'D BY REGISTRAR <b>4217-95</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>JUL 12 1966</b>											

10150

10150

10150

10123

## CERTIFICATE OF DEATH

10121

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>4612 Coach Way Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>C</u> Last <u>Grover</u>		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>57</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter P. Harlow</u>		14. MOTHER'S MAIDEN NAME <u>Anna Fischer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Benjamin I. Harlow - Husband same item #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>8-10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/8</u> , 19 <u>66</u> to <u>7/10</u> , 19 <u>66</u> that (I) (we) lost saw the deceased alive on <u>7/10</u> 19 <u>66</u> and that death occurred at <u>3:30</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>H. C. PAGANZINI</u>		22b. DATE SIGNED <u>7/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. C. PAGANZINI</u>		22d. ADDRESS <u>50W Edmonston Dr., Rockville, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/13/77</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Hyman &amp; Hales</u>		ADDRESS <u>1331 Rockville Pike</u> <u>Rockville, Maryland</u>	
25a. REC'D BY REGISTRAR <u>JUL 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

Charged by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ES 101

ESTDA

FOR STATE  
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

10130

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10122

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
c. LENGTH OF STAY IN lb <u>341.</u>		d. STREET ADDRESS <u>11426 Maple View Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belmont Nursing Home.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Ether</u> Middle <u>Grubbs</u> Last		4. DATE OF DEATH <u>July</u> Month <u>13</u> Day <u>1966</u> Year	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/XX/1876</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi Shaw</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Leizear</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>579-10-2951D</u>	
17. INFORMANT <u>Mr. Stanley E. Gaub</u> Address <u>11426 Maple View Dr. Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion and edema</u> DUE TO (b) <u>due to Inanition</u> DUE TO (c) <u>cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>334X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u> <u>7936 Old Georgetown Rd. Bethesda, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 16, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10131

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10123

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md</b> c. LENGTH OF STAY IN lb <b>1hr</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> <b>15 - 1</b>	
3. NAME OF DECEASED (Type or print) <b>Percy Clagett Guthridge Sr</b>		4. DATE OF DEATH Month <b>7</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/29/07</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>18</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Filling Station Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Richards Guthridge</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Guthridge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-07-2095</b>	
17. INFORMANT <b>James Guthridge, Son, 3013-Blueford Rd.</b>		Address <b>Kensington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple Sclerosis (20 yrs)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Beloen R. Peap</b> EXAMINER'S NAME (Type) <b>BELOEN R. PEAP, M.D.</b>		22. DATE SIGNED <b>7/18/1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-21-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>HYSOING'S FUNERAL HOME - 1300 N ST. N.W. WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>JUL 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>James M. Hyson</b>			

10136

RECEIVED - 10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

10136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The place remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10132

CERTIFICATE OF DEATH

10124

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>74 YRS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>Kendall Green</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ethel Taylor</u> First Middle Last		4. DATE OF DEATH <u>July 4</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1878</u>
9. AGE (In years last birthday) yrs. <u>88</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>IOWA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>MARION Morgan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Johnathan Hall-Son</u>		Address <u>10501 Drumm Avenue Kensington, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GRAM NEGATIVE SEPTICEMIA</u> DUE TO (b) <u>URINARY TRACT INFECTION</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>609x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>2 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ATHEROSCLEROSIS RECENT FRACTURE LEFT HIP</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19 59</u> to <u>JULY 4</u> , 19 <u>66</u> that (I) (we) lost the deceased on <u>JULY 4</u> , 19 <u>66</u> , and that death occurred at <u>0455 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward A. Beeman</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>		22d. ADDRESS <u>1015 SPRING ST. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>7/5/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>JUL 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

4501

5872

— 14 —

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10133

## CERTIFICATE OF DEATH

10125

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
c. LENGTH OF STAY IN lb <b>2 Days</b>		83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		d. STREET ADDRESS <b>8326 Blowing Rock Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marjorie Middleton HANCOCK</b>		4. DATE OF DEATH Month Day Year <b>12 July 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 October 1918</b>
9. AGE (In years last birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Mobile, Alabama</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Whitwell Middleton</b>		14. MOTHER'S MAIDEN NAME <b>Kate Munson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>416 12 8105</b>	
17. INFORMANT <b>Alex F. Hancock</b>		Address <b>8326 Blowing Rock Rd., Alexandria, Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma lung with metastases</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <b>10 July</b> , 19 <b>66</b> , to <b>12 July</b> , 19 <b>66</b> , that (b) (we) last saw the deceased alive on <b>12 July</b> , 19 <b>66</b> , and that death occurred at <b>12</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Peter T. Kirchner</b>		22b. DATE SIGNED <b>13 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER T KIRCHNER</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-15-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Memorial Chapel</b>	23d. LOCATION (City or town) (County) (State) <b>Alexandria, Virginia</b>
24. FUNERAL DIRECTOR <b>Demaine Memorial Chapel, 520 S. Washington St. Alexandria, Virginia</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

10185

RECORD OF DEEDS

10185

PETER T. KIRCHER



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rothesda-Rockville</b> c. LENGTH OF STAY IN 1b <b>Don't know years.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital 1707 Tweed St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>1707 Tweed Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>W.</b> Last <b>HANDKE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent of Schools - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Arnold Handke</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Barnes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wife</b> <b>Marion Handke</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute -</b> <b>4201</b> DUE TO (b) <b>Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b> <b>Years.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		22. DATE SIGNED <b>July 14, 1966</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/18/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Rockville Maryland</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10158

RECORDS OF THE DISTRICT OF COLUMBIA

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MONTGOMERY STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
10135					CERTIFICATE OF DEATH					10127				
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>7 MINUTES</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>					15-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>					d. STREET ADDRESS <b>3605 HINES ROAD</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>BOY</b> Last <b>HARDY</b>					4. DATE OF DEATH Month <b>JULY</b> Day <b>15</b> Year <b>19 66</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>JULY 15, 1966</b>		9. AGE (In years last birthday) - yrs.		IF UNDER 1 YEAR Months - Days -		IF UNDER 24 HRS. Hours - Mins. -		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEWBORN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>			11. BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY COUNTY, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>--</b>					14. MOTHER'S MAIDEN NAME <b>DOROTHY HARDY</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO --</b>			16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>			Address <b>OLNEY, MARYLAND</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7615 Cardio Respiratory Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Intrauterine Anoxia</b> DUE TO (c) <b>Prolonged Labor</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>6 wks Premature</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>5:30 P.</b> M, from causes and on the date stated above.														
22a. SIGNATURE <b>John R. Spencer</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>7-15-66</b>						
22c. PHYSICIAN'S NAME (Type) <b>JOHN R. SPENCER, M.D.</b>					22d. ADDRESS <b>BURTONSVILLE, MARYLAND</b>									
23a. BURIAL CREMATION-REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopkins Chapel</b>			23d. LOCATION (City or Town) (County) (State) <b>Highland, Md.</b>							
24. FUNERAL DIRECTOR <b>Robert L. Swowles</b>					ADDRESS <b>Rockville, Md</b>		25a. REC'D BY REGISTRAR <b>JUL 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

1953

STATE OF NEW YORK

1953

STATE OF NEW YORK

STATE OF NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Asbury Methodist Home for the Aged, Inc.</b>					d. STREET ADDRESS <b>113 Melvin Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Eliza</b>		Middle <b>Grace</b>		Last <b>Hardy</b>		4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 24, 1875</b>		9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher - retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George E. W. Hardy</b>					14. MOTHER'S MAIDEN NAME <b>Eliza J. Regester</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-46-6952</b>		17. INFORMANT <b>Asbury Methodist Home, Gaithersburg, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 332X DUE TO (b) <b>Cerebrovascular Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Generalized Arteriosclerosis</b>									INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>7 YRS</b> <b>75 YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/1/62</b> , 19 to <b>7/21/66</b> , 19, that (I) (we) last saw the deceased alive on <b>7/21/66</b> , 19, and that death occurred at <b>940 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Henry C. Scruggs MD</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/21/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>HENRY C. SCRUGGS MD</b>					22d. ADDRESS <b>5413 Cedar Lane Bethesda Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery Baltimore, Md.</b>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <b>Wm. J. Tubman &amp; Sons Baltimore, Md.</b>					25a. REC'D BY REGISTRAR <b>JUL 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158

10158



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookville</i> c. LENGTH OF STAY IN 1b <i>1 Year</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>R.F. &amp; #</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookville</i> d. STREET ADDRESS <i>R.F. &amp; #</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>RICHARD TRAVIS HARLAN</i> First Middle Last		4. DATE OF DEATH Month Day Year <i>JULY 7 1966</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 31 1905</i>	9. AGE (In years last birthday) <i>60</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rod Man Steel</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Tanner Stanton Harlan</i>			14. MOTHER'S MAIDEN NAME <i>Hibernia Olive Baner</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>136-03-1281</i>		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Coronary Artery Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Belden R. Reap</i>		M.D. <i>BELDEN R. REAP, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>July 7, 1966</i>
EXAMINER'S NAME (Type) <i>BELDEN R. REAP</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>Wheaton</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>July 17 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Crewe</i>		23d. LOCATION (City, town, or county) (State) <i>Crewe Neptowa Virginia</i>
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>		ADDRESS <i>Laytonsville Md</i>		25a. REC'D BY REGISTRAR <i>JUL 19 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

James H. Barber Daytonville Mo

July 17 1966

Crows

Notowa

Virginia

Removal

Unknown

Tanner Stanton Harlan

Hibernia Olive Branch

Steel Construction

Virginia

U.S.A.

Dec 31 1965

1 Year

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10138

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10130

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1503 Belgaro Road</u>	
3. NAME OF DECEASED (Type or print) <u>James Fullerton Hartley</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Med. Corpsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Med. Corpsman</u>	9. AGE (In years) <u>42</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hartley</u>		14. MOTHER'S MAIDEN NAME <u>Alma Fullerton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes 5/41 7/66</u>		16. SOCIAL SECURITY NO. <u>081-32-1469</u>	
17. INFORMANT <u>Shirley Hartley, Laurel, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to</u> DUE TO (b) <u>overdose of barbiturate while intoxicated</u> DUE TO (c) <u>lost.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased took overdose of barbiturate while intoxicated</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>3:00</u> <u>7-9</u> 19 <u>66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Laurel</u> <u>Howard</u> <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>July 9, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Ce,</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Va</u>
24. FUNERAL DIRECTOR <u>Donaldson Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 26 1966</u>	
ADDRESS <u>Laurel, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10130

10130

10130

10130

10139

CERTIFICATE OF DEATH

10131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>24 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>River Edge</b> 67.3		d. STREET ADDRESS <b>862 Summit Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>Bernard</b> Last <b>HAUSER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1915</b>
9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer/Sales Represent. Manufacturing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hoboken, New Jersey</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fred Hauser</b>		14. MOTHER'S MAIDEN NAME <b>Mae Carlin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Mrs. Sofia Hauser, 862 Summit Avenue, River Edge, N. J.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myelocytic leukemia</b> 2043 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>it</del> (this hospital) attended the deceased from <b>June 20</b> , 1966, to <b>July 14</b> , 1966, that <del>it</del> (we) last saw the deceased alive on <b>July 14</b> , 1966, and that death occurred at <b>900P M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>R. H. Easterday</i>		22b. DATE SIGNED <b>July 15, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. H. EASTERDAY, M.D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 18, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Fairview New Jersey</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b> ADDRESS <b>1400 Chapin Street, N.W., Washington, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 18 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101



10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101

10101



10140

## CERTIFICATE OF DEATH

10132

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>DISTRICT OF COLUMBIA</b> D. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>WASHINGTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SYLVAN MANOR NURSING HOME</b>		d. STREET ADDRESS <b>4020 RENO ROAD, N. W.</b>	
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>ELIZABETH</b> Last <b>HAWKEN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>4</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1875</b>
9. AGE (In years last birthday) yrs. <b>91</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ely Riley</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Brooke</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Stafford W. Hawken, Son</b>		Address <b>Same as #2 above.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Congestive Heart Failure</b> DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-3-66</b> , 19 <b>66</b> , to <b>7-4</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-3-66</b> 19 <b>66</b> , and that death occurred at <b>2:00 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Ronald W. Barr, M.D.</b>		22b. DATE SIGNED <b>7/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ronald W. Barr, M.D.</b>		22d. ADDRESS <b>10401 Old Georgetown Rd., Bethesda</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>7/5/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Jos. Gawler's Sons, Inc., Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>JUL 8 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

10115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>107 Sheridan Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>TIRZAH</u> First Middle Last <u>NMM Hendryx</u>		4. DATE OF DEATH Month Day Year <u>7 15 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-21-79</u> 9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Ore.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Owen Barton</u>	
14. MOTHER'S MAIDEN NAME <u>Garlets</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Renal Insufficiency</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 14, 1966</u> , and that death occurred at <u>4:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>James M. Whitlock</u>		22b. DATE SIGNED <u>7-15-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>		22d. ADDRESS <u>7717 Canal Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 20, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baker, Oregon</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Wallace</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Arthur Wallace</u>		25c. REGISTRAR'S SIGNATURE <u>J. Arthur Wallace</u>	

66101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1703 East West Hgw.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH		Middle HERTZOFF		Last 7	
4. DATE OF DEATH Month 7		Day 27		Year 19 66	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4/20/88		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Kusiel Kesler		14. MOTHER'S MAIEN NAME Esther	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Julius Okun	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO (b) AORTIC ANEURYSM. DUE TO (c) ARTERIO-SCLEROSIS.		19. INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from July, 1966, to 7-27, 1966, that (I) (we) last saw the deceased alive on 7-27, 1966, and that death occurred at 9:57 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Robert Kramer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert Kramer		22d. ADDRESS 8484 - 16th St., SS, Md.		22b. DATE SIGNED 7-27-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/28/66		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden Cem. Falls Ch., Va.	
23d. LOCATION (City, town or county)		(State)		24. FUNERAL DIRECTOR Bernard Danzansky & Sons N.W., Wash., D.C.	
25a. REC'D BY REGISTRAR JUL 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

101111

3430

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>10143</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>10135</p> </div> </div> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>									
<p>1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>??</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Hall Sanitarium</b></p>				<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington Silver Spring 15-1</b> d. STREET ADDRESS <b>911 Lexford Terrace 10231 Carroll Pk., Kensington</b></p>					
<p>3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>Heuck</b> Last <b>Heuck</b></p>				<p>4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1966</b></p>					
<p>5. SEX <b>Female</b></p>		<p>6. COLOR OR RACE <b>White</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>April 14, 1884</b></p>		<p>9. AGE (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b> Hours <b>Min.</b></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Germany</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>John Gaiser</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Christine Frey</b></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <b>Unknown</b></p>		<p>17. INFORMANT Address <b>Carroll Hall Sanitarium</b></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia Bilateral</b> 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b></p>								<p>INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitis and arterio-sclerosis generalized</b></p>									
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (1) (this hospital) attended the deceased from <b>July 28, 1966</b>, to <b>July 29, 1966</b>, that (2) (we) last saw the deceased alive on <b>July 28, 1966</b>, and that death occurred at <b>8:21 AM</b>, from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE <b>Alfred S. Norton</b></p>				<p>22b. DATE SIGNED <b>July 29, 1966</b></p>				<p>22c. PHYSICIAN'S NAME (Type) <b>Alfred S. Norton</b></p>	
<p>22d. ADDRESS <b>7710 Dwight Drive, Bethesda, Md.</b></p>				<p>22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b></p>		<p>23b. DATE THEREOF <b>7/29/1966</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>Colonial Mem. Park Cem</b></p>		<p>23d. LOCATION (City, town or county) (State) <b>Hamilton Township N. J.</b></p>			
<p>24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b></p>				<p>ADDRESS <b>Bethesda, Maryland</b></p>		<p>25a. REC'D BY REGISTRAR <b>AUG 2 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles J. J.</b></p>			

10135

10135

Longmont, Colo.

MARY ANN

Longmont, Colo.

Longmont, Colo.

Longmont, Colo.

1051 Central Ave., Longmont, Colo.

Central Hall, Longmont, Colo.

Longmont, Colo.

Longmont, Colo.

April 14, 1884 32 18

White 32 18

USA

Germany

-----

Honorable

Christine A. Rev.

John Gaiser

Central Hall, Longmont, Colo.

Unknown

NO

July 29, 1966

7710 Wright Drive, Bethesda, Md.

Alfred S. Norton

Colonial Mem. Park Com. Hamilton Township, N.J.

Trans-transit 7/29/1966

Bethesda, Maryland

Robert A. Pamphrey

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10144

## CERTIFICATE OF DEATH

10136

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>103 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		d. STREET ADDRESS <b>RFD #2, Box 183</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Philip Blaine HINES</b>		4. DATE OF DEATH Month Day Year <b>July 6 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 June 1942</b>
9. AGE (In years lost birthday) yrs. <b>24</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>24</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pierce City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Blaine Hines</b>		14. MOTHER'S MAIDEN NAME <b>Anna Maude Hawkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Jul 1961-66</b>		16. SOCIAL SECURITY NO. <b>514 42 2063</b>	
17. INFORMANT <b>Blaine Hines</b>		Address <b>RFD#2, Box 183, Galena, Kansas</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fulminating generalized infection including pyelonephritis and pelvic abscesses</b> DUE TO (b) <b>Wound infection and pyelonephritis</b> DUE TO (c) <b>Gunshot wound, left hip with multiple comminuted fractures of left hip and perforation of urinary bladder.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Wounded in action Rep. of Viet Nam</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>night 3 20 19 66</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rice Paddy</b>	20f. (City or town) (County) (State) <b>Rep. Viet Nam</b>
21. I certify that (X) (this hospital) attended the deceased from <b>28 May</b> , 19 <b>66</b> , to <b>6 July</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>6 July</b> , 19 <b>66</b> , and that death occurred at <b>7:35 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>x Edward C. Gilbert</b>		22b. DATE SIGNED <b>8 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Gilbert LCDR MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-11-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>W.W. Chambers Co. Inc</b>	23d. LOCATION (City or Town) (County) (State) <b>Joplin, Mo.</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc</b>		25a. REC'D BY REGISTRAR <b>W.W. Chambers Co. Inc</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUL 12 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10130

TECHNICAL OF-0141

1014

10130

10130

10130

10130

U.S. Bureau of the Census, Washington, D.C.

10130

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

U.S. Bureau of the Census, Washington, D.C.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

Item 23b Film G379 8/1/66 mh

**CERTIFICATE OF DEATH**

10145

10137

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN lb <u>46 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1 d. STREET ADDRESS <u>5603 Dowgate Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Rhonda Sue Hinton</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>July 24 1966</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Cauc</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>24 July 1966</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>00</u> <u>46</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Not Applicable</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Not Applicable</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Montgomery, Maryland</u>			
<b>13. FATHER'S NAME</b> <u>Benny Ray HINTON</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Helen COLE</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Not Applicable</u>		<b>17. INFORMANT</b> <u>5603 Dowgate Court, Benny Ray HINTON Rockville, Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>21. I certify that</b> <del>(I)</del> (this hospital) attended the deceased from <u>July 24</u> , 19 <u>66</u> to <u>July 24</u> , 19 <u>66</u> , that <del>(I)</del> (we) last saw the deceased alive on <u>July 24</u> , 19 <u>66</u> , and that death occurred at <u>631P</u> M, from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Jerry J. Tomasovic</u>			<b>22b. DATE SIGNED</b> <u>July 25, 1966</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Jerry J. Tomasovic M. D.</u>		
<b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>			<b>22e. REC'D BY REGISTRAR</b> DATE <u>JUL 28 1966</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>July 26, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bistinean Cemetery</u>			
<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Heflin, Louisiana</u>		<b>24. FUNERAL DIRECTOR</b> <u>R. A. Pumphrey Funeral Home</u> <u>7557 Wisconsin Ave., Bethesda, Maryland</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10117

OFFICE OF DEATH

10117

x

10117

10117

Name		J. P. [illegible]	
Address		[illegible]	
City		[illegible]	
State		[illegible]	
Date of Birth		[illegible]	
Date of Death		[illegible]	
Cause of Death		[illegible]	
Place of Death		[illegible]	
Occupation		[illegible]	
Marital Status		[illegible]	
Education		[illegible]	
Religion		[illegible]	
Race		[illegible]	
Sex		[illegible]	
Height		[illegible]	
Weight		[illegible]	
Complexion		[illegible]	
Build		[illegible]	
Hobbies		[illegible]	
Family		[illegible]	
Social History		[illegible]	
Medical History		[illegible]	
Surgical History		[illegible]	
Mental History		[illegible]	
Substance Use		[illegible]	
Other		[illegible]	

10117

10117



FOR STATE  
HEALTH DEPT.

10146

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10138

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5503 Britz Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Rogee</u> First <u>Patton</u> Middle <u>Hollingsworth</u> Last <u>Patton</u>		DATE OF DEATH <u>7-16</u> Month <u>7</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>citizen</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Walter Hollingsworth</u>		14. MOTHER'S MAIDEN NAME <u>Letitia Patton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes W.W.I</u>		16. SOCIAL SECURITY NO. <u>W.W.I</u>	
17. INFORMANT <u>Wife - Frances - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4201 DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>last</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <u>July 16, 1966</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	
23b. DATE THEREOF <u>7/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	
23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>		24. FUNERAL DIRECTOR <u>S.H. Hanes Co. Wash. D.C.</u>	
25a. REC'D BY REGISTRAR <u>JUL 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10134

10140

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10147

10139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Maryland</i> c. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN IB <i>5HR - 25 MIN</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>3406 Glories place</i>	
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>Grant</i> Last <i>Holmes</i>		4. DATE OF DEATH Month <i>July</i> Day <i>13</i> Year <i>1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-18-08</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Miss Totato Chip Co.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Lyconia - Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Robert Holmes</i>		14. MOTHER'S MAIDEN NAME <i>Mrs Bowman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes - Army - 1943 to Nov 1945</i>		16. SOCIAL SECURITY NO. <i>4201</i>	
17. INFORMANT <i>Margorie Holmes - wife - add same</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 12, 1966</i> to <i>July 13, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 13, 1966</i> , and that death occurred at <i>12:40 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert R. Montgomery</i> M.D.		22b. DATE SIGNED <i>7-13-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>		22d. ADDRESS <i>5411 CEDAR LANE BETHESDA, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>7-15-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Montoursville Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Montoursville PA.</i>	
24. FUNERAL DIRECTOR <i>Ives Funeral Home</i> by: <i>Ben E. Payne</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 18 1966</i>	
ADDRESS <i>2847 Wilson Blvd. ARLINGTON, VA.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10130

CERTIFICATE OF DEATH

10130

STATE OF NEW YORK

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

10130

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10148					10140				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Montgomery MARYLAND					a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 15-1				
c. LENGTH OF STAY IN 1b 1 day					d. STREET ADDRESS 25 Holt Place				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hosp.					e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Baby Boy Holt					4. DATE OF DEATH 7-21 1966				
5. SEX Male					6. COLOR OR RACE W				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 7-20-66				
9. AGE (In years last birthday) - yrs.					10. IF UNDER 1 YEAR Months Days Hours Mln.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Albert Kinley Holt					14. MOTHER'S MAIDEN NAME PATRICIA Ann Phelps				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
17. INFORMANT					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 7593 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple congenital defects DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 11:28 AM, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on ____, 19__, and that death occurred at ____, M, from the causes and on the date stated above.									
22a. SIGNATURE H.H. Diamond									
22b. DATE SIGNED 7/21/66									
22c. PHYSICIAN'S NAME (Type) H.H. DIAMOND									
22d. ADDRESS 911 SILVER SPRING AVE S.S. Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation									
23b. DATE THEREOF 7-25-66									
23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital, Takoma Park, Maryland									
23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR H.S. Nelson, Washington San. & Hospital									
25a. REC'D BY REGISTRAR JUL 26 1966									
25b. REGISTRAR'S SIGNATURE Charles Judge									

6-207580

10140

*[Faint, illegible handwriting across the page]*

*[Faint, illegible handwriting at the bottom of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>73 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annandale</b>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					d. STREET ADDRESS <b>3805 Lake Boulevard</b>				
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Jane</b> Last <b>Hudson</b>			4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 10, 1911</b>		9. AGE (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR: Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physical Scientist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Science</b>		11. BIRTHPLACE (County & State, or foreign country) <b>California</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David R. Johnston</b>					14. MOTHER'S MAIDEN NAME <b>Kathryn Mortensen</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>228-24-0022</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse, Acute</b> 410X DUE TO (b) <b>Chronic congestive heart failure</b> 5 months (c) <b>Rheumatic Heart Disease with mitral-tricuspid valve disease</b> 20 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic renal disease, cardiac cirrhosis, chronic respiratory insufficiency</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 hr. 45 MI</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>D</b> (this hospital) attended the deceased from <b>May 15, 1966</b> , to <b>July 27, 1966</b> , that <b>W</b> (we) last saw the deceased alive on <b>July 27, 1966</b> , and that death occurred at <b>2:48 M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Sewell H. Dixon, Jr., M.D.</b>					22b. DATE SIGNED <b>28 July 1966</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Sewell H. Dixon, Jr., M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>July 30, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR By <b>Charles Judge</b>			24a. ADDRESS <b>10565 Main Street, Fairfax, Va.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1911

1912

California

Virginia

Montgomery

Annals

73 days

Bedford

The Clinical Center, Bedford, Maryland, 3005 Lake Boulevard

60

July

London

June

Elizabeth

October 10, 1911 5A

White

Female

U.S.A.

California

Science

Physical Scientist

Raymond H. Johnston  
The Medical Research

David H. Johnston

425-4202 The Clinical Center, Bedford, Maryland

No

Cardiovascular collapse, acute

5 months

Chronic congestive heart failure

Rheumatic heart disease with mitral-tricuspid

40 years

valve disease

insufficiency

coronary artery disease, cardiac arrhythmia, chronic respiratory

July 17, 1911  
May 15, 1911  
July 17, 1911

28 July 1911

The Clinical Center, National  
Institute of Health, Bethesda, Maryland

David H. Johnston, Jr., M.D.

10150

CERTIFICATE OF DEATH

10142

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>833</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
c. LENGTH OF STAY IN 1b <u>31 days</u>		d. STREET ADDRESS <u>867 Abingdon Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Harry HUGHES, JR.</u>		4. DATE OF DEATH Month Day Year <u>July 19 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Sept 1918</u>
9. AGE (In years last birthday) <u>47 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Marine Corps</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USMC (Ret.)</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Harry Hughes, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Philomena Reinhardt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1942-1966</u>		16. SOCIAL SECURITY NO. <u>227-01-6046</u>	
17. INFORMANT <u>Mrs. Rosalie K. Hughes,</u>		Address <u>867 Abingdon St., Arlington, Virginia</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Acute fibrinous peritonitis</u> DUE TO (b) <u>post operative, Acute pancreatitis, Dehiscence</u> DUE TO (c) <u>of duodenal stump, Paralytic ileus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 17</u> , 19 <u>66</u> , to <u>July 19</u> , 19 <u>66</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 19</u> , 19 <u>66</u> , and that death occurred at <u>725A</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>L. C. Getzen</u>		22b. DATE SIGNED <u>19 July 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. C. GETZEN M.D.</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/22/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Murphy Funeral Home</u> ADDRESS <u>W. J. Madison</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 21 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10145

10145

RECEIVED

10145

10145



10145

10145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>178 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Minnesota</u> <span style="float: right;">✓</span> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Robbinsdale</u> d. STREET ADDRESS <u>3940 Orchard Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Marvin Arden Husby</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>July 3 1966</u> Month Day Year						
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>17 September 1914</u>		<b>9. AGE</b> (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Machine Shop</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Minnesota</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Christopher Husby</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Edith Nelson</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>---</u>				<b>16. SOCIAL SECURITY NO.</b> <u>484-07-2598</u>		<b>17. INFORMANT</b> <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Klebsiella pneumonia and septicemia</u> 205X CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>Mycosis fungoids</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mitral Insufficiency</u> <u>Rheumatic heart disease, Aortic Stenosis, Aortic Insufficiency,</u>									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u> <u>3 1/2 years</u>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <u>he</u> (this hospital) attended the deceased from <u>6 January</u> , 19 <u>66</u> to <u>3 July</u> , 19 <u>66</u> , that <u>he</u> (we) last saw the deceased alive on <u>3 July</u> , 19 <u>66</u> and that death occurred at <u>9:30M</u> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Martin H. Cohen</u>					<b>22b. DATE SIGNED</b> <u>3 July 1966</u>				
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Martin H. Cohen, M.D.</u>					<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-transit 7-4-66</u>		<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Christle Lake Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Minneapolis, Minn.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					<b>25a. REC'D BY REGISTRAR</b> <u>JUL 7 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		

10143

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

USA

USA

USA

USA

Minnesota

Minnesota

Minnesota

USA

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota

Minnesota



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10152					10144				
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b <i>14 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i> <i>47 3</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Althea Woodland Nursing Home</i>					d. STREET ADDRESS <i>227 Constitution Ave. N. E.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Orlie</i> Middle <i>Stine</i> Last <i>Huss</i>		4. DATE OF DEATH Month <i>7</i> Day <i>7</i> Year <i>19 66</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4 - 3 - 18 85</i>		9. AGE (In years last birthday) <i>81 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Frank Stine</i>				14. MOTHER'S MAIDEN NAME <i>Johanna McCormick</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-22-4577</i>		17. INFORMANT <i>Mr. James P. Huss</i>		Address <i>Silver Spring, Md. 304 White Stone Road</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardio Vascular Disease</i> <i>1443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>R. H. Hemiplegia</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19 <i>60</i> to <i>July 7</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>6-29</i> 19 <i>66</i> , and that death occurred at <i>2:45 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Geo. R. Huffman</i>				22b. DATE SIGNED <i>7-7-66</i>					
22c. PHYSICIAN'S NAME (Type) <i>George R. Huffman</i>				22d. ADDRESS <i>1912 R St., N.W., Washington, D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 11, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oakmont Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Waynesburg, Penna.</i>			
24. FUNERAL DIRECTOR <i>Glen Carter Warner &amp; Pumphrey, Inc.</i>				ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

E2104

## REFERENCES

- 2 -

17

233

424

1000

11-10-10 10:34-10:35

"Doubtful,"

1950-51 20 2018 20

*[Faint handwritten notes at the bottom of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10153					10145				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>					d. STREET ADDRESS <b>8207 Mapleridge Road</b>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <b>MAMIE</b> Middle <b>E.</b> Last <b>HUTH</b>					Month <b>July</b> Day <b>7</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 25, 1885</b>		9. AGE (In years last birthday) <b>80</b> yrs.	
								IF UNDER 1 YEAR Months <b>10</b> Days <b>12</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Tel. Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Charles H. Huth</b>					14. MOTHER'S MAIDEN NAME <b>Ada J. Osborn</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>577-01-1703-A</b>		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 OUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO <b>Dissection</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>7/5</b> 19 <b>66</b> to <b>7/7</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>7/6</b> 19 <b>66</b> , and that death occurred at <b>9:30AM</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>W. T. JOYCE</b>					22b. DATE SIGNED <b>7-7-66</b>			22c. PHYSICIAN'S NAME (Type) <b>W. T. JOYCE</b>	
22d. ADDRESS <b>4977 Battery Lane, Bethesda, Md.</b>					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>July 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Washington Dist. of Col.</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumfrey</b>					ADDRESS <b>Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1966</b>		
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

Robert A. Humphrey, Washington, D.C.

Burial July 8, 1988 Congressional Cem. Washington, D.C. of Col.

W. J. JAYCE

1007 Barclay Lane, Bethesda, Md.

9:30 AM

7-7-88

275-01-1702-

Charles H. Webb

Adm. J. Anderson

United States Col. Tol. Co.

July 22, 1988

July

WALL

Continental Hospital

Leeds

Geography

Mapland

1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10154					10146				
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Essex				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Clarksburg			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark 67-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD # 1					d. STREET ADDRESS 81 Mott St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Johanna		First Middle Last Ihrig		4. DATE OF DEATH Month Day Year July 1 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1882		9. AGE (in years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Battor, Austria			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME unknown Koller				14. MOTHER'S MAIDEN NAME Christina Koller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Stella Marshall, Clarksburg, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 6 days 7 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>was</del> attended the deceased from 7/26, 1966, to 7/1, 1966, that (I) <del>was</del> last saw the deceased alive on 7/1, 1966, and that death occurred at 7:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE James P. Kerr				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/1/66			
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.				22d. ADDRESS Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 5, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town or county) (State) E. Orange, N.J.			
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				ADDRESS		25a. REC'D BY REGISTRAR JUL 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

101110

RECEIVED

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110

101110



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3  
1  
M  
cleared with medical examiner. Jha  
Page 1

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10155		10147	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakons Park</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Elder, Karen 7300-Balto Ave - 7103 Sycamore</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakons Park - Md</i> d. STREET ADDRESS <i>16-2</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FRIEDA</i> First Middle Last 4. DATE OF DEATH <i>July 11</i> 19 <i>66</i> Month Day Year		5. SEX <i>F.</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>Jan 29, 1882</i> 9. AGE (In years last birthday) <i>84</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mid wife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Germany -</i> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Kalter Schlegel</i> 14. MOTHER'S MAIDEN NAME <i>Dorothea</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>—</i> 16. SOCIAL SECURITY NO. <i>—</i> 17. INFORMANT <i>Mrs. Dorothea Boyd</i> Address <i>7114 - Willow Tree - Sakons Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Myocarditis</i> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Vascular accident, 6 years previous.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> , 19 <i>66</i> , to <i>July</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>May</i> , 19 <i>66</i> , and that death occurred at <i>1:59</i> P.M., from the causes and on the date stated above.		22a. SIGNATURE <i>John N. Andrews</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <i>John N. Andrews</i> 22d. ADDRESS <i>1601 Colesville Rd Silver Spring Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>July 13, 1966</i> 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery, Bladensburg, Md</i> 23d. LOCATION (City, town or county) (State) <i>Md</i>		24. FUNERAL DIRECTOR <i>Arthur Walter</i> ADDRESS <i>754 Central St - D.C.</i> 25a. REC'D BY REGISTRAR <i>JUL 15 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	

1011

78157



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

BP Cleared with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10156 CERTIFICATE OF DEATH 10148											
Items 20, 20a fill 6/15/66 mh											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>					d. STREET ADDRESS <b>3400 Fairland Rd,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Irene</b>			First <b>B</b> Middle <b>Jackson</b> Last		4. DATE OF DEATH <b>July 11, 1966</b>		Month <b>July</b> Day <b>11</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 16, 1893</b>		9. AGE (In years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Robert Williams</b>					14. MOTHER'S MAIDEN NAME <b>Minnie Johnson</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Robert Williams: Item #2</b>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Myocarditis</b> <b>443X</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>60</b> , to <b>July</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>July 11</b> , 19 <b>66</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John N. Andrews</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>July 11-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>					22d. ADDRESS <b>9601 Cokesville Rd. Silver Spring Md</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>7-14-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Round Oak.,</b>		23d. LOCATION (City, town or county) (State) <b>Spencerville, Md.</b>				
24. FUNERAL DIRECTOR <b>George R. Snowden</b>					ADDRESS <b>Rockville Md</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10113

STATE OF NEW YORK

10113

County of ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 5 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10157

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10149

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Shirley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirley</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>Walnut Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13507 Bartlett Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRIET SCARFF JOHNSON</u>		4. DATE OF DEATH <u>July 5, 1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>
13. FATHER'S NAME <u>Russell Scarff</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Kendall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>308-12-6883</u>	
17. INFORMANT <u>Mrs. Clifford Scarff (Sister-in-law)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Coronary insufficiency</u> DUE TO (b) <u>due to Rheumatic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-6-66</u>		23b. DATE THEREOF <u>7-6-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wilkinson, Indiana</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>1331 Rockville Pike, Rockville, Md.</u>		DATE <u>JUL 8 1966</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>83 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairfax</b> <b>83-3</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		d. STREET ADDRESS <b>3803 Estel Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Dare</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 June 1916</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Haittgras, North Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Nelson Stowe</b>	
14. MOTHER'S MAIDEN NAME <b>Ursula Ballance</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>139-18-8139</b>		17. INFORMANT <b>Mr. Edwin E. Johnson</b> <b>Fairfax, Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Carcinoma of breast with metastases</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from <b>11 April</b> , 19 <b>66</b> , to <b>2 July</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>2 July</b> , 19 <b>66</b> , and that death occurred at <b>6:10AM</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>P.B. Blanchard</b>		22b. DATE SIGNED <b>2 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>P.B. BLANCHARD LT., MC, USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 6, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Arlington Va.</b>	
24. FUNERAL DIRECTOR <b>David N. Branda</b> <b>Everly Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUL 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10120

EXTRACT OF DEATH

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

10120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10153

CERTIFICATE OF DEATH

10151

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN Tb <u>1 mo. 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Baswell Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>O.</u> Last <u>JOHNSON</u>				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/81</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Rockland Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm R. Knott</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Eglin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ada L. Stinson</u> Address <u>10028 Pine Rd. Palmdale, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure, arteriosclerosis</u> DUE TO (b) <u>Cardio vascular disease</u> DUE TO (c) <u>Pericardial Sineu curthousis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>3pm</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Gene U. Cohen MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN</u>				22d. ADDRESS <u>1106 SPRING ST SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUL 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12111

08102

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10160

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10152

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boysd, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boysd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bucklodge Rd.</i>		d. STREET ADDRESS <i>Bucklodge Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Michael Justus</i>		4. DATE OF DEATH <i>7-24-66</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-9-1964</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Leonard Justus</i>		14. MOTHER'S MAIDEN NAME <i>Cynthia Justus</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mother</i>		Address <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured skull, left</i> DUE TO (b) <i>temporo-parietal area,</i> DUE TO (c) <i>comminuted.</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II of item 18.) <i>Car, parked brake accidentally released &amp; open car door knocked child under wheel.</i>	
20c. TIME OF INJURY Month, Day, Year <i>8:45 p.m. 7-24-1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Driveway</i>		20f. (City or town) <i>Boysd, Montgom. Md.</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/26/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>		23d. LOCATION (City or Town) <i>Beallville Montg. Md</i> (County) (State)	
24. FUNERAL DIRECTOR <i>Constance C. Hilton Barnesville Md</i>		25a. REC'D BY REGISTRAR <i>JUL 28 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		22. DATE SIGNED <i>7/24/1966</i>	

1915

MADE IN CANADA

1915

1915

1915

1915



4  
2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10161					10153						
1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY COUNTY</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MONTGOMERY</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>			c. LENGTH OF STAY IN 1b <i>7 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>			15-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>HOLY CROSS HOSPITAL OF SILVER SPRING</i>					d. STREET ADDRESS <i>75 E. WAYNE AVE.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>JOSEPH Francis KELLY</i>			4. DATE OF DEATH Month Day Year <i>JULY 27 1966</i>								
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/9/08</i>		9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALES REPRESENTATIVE</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>GEN. ELECTRIC</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Phila. Penna.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Francis Kelly</i>					14. MOTHER'S MAIDEN NAME <i>Anna Kelly</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>			16. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>WW II</i>		17. INFORMANT <i>Ethel B. Kelly</i> Address <i>75 E. Wayne Ave. Silver Spring, Maryland</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cor pulmonale</i> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pulmonary arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>1961</i> , 19 <i>29 July</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>26 July</i> 19 <i>66</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Ira N. Tublin</i>					22b. DATE SIGNED <i>7/27/66</i>						
22c. PHYSICIAN'S NAME (Type) <i>Ira Tublin, M.D.</i>					22d. ADDRESS <i>800 PERSHING DRIVE. S.S.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Aug. 1, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westminster Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Philadelphia, Pennsylvania</i>				
24. FUNERAL DIRECTOR <i>John B. Thomas</i> ADDRESS <i>Warner E. Humphrey, Inc. Silver Spring, Md.</i>					25a. REC'D BY REGISTRAR <i>AUG 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

10131

10131

10131

FOR INFORMATION

FOR INFORMATION

10131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Dr. Bell

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10162					10154						
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b <i>9 DAYS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Sp. 8600 16th St.</i>			d. STREET ADDRESS <i>Silver Spring, 15-1</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>					6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>F</i>		First <i>Edward</i>		Middle <i>Kernan</i>		Last <i>Kernan</i>		4. DATE OF DEATH Month <i>July</i> Day <i>15</i> Year <i>1966</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/1/07</i>		9. AGE (in years last birthday) <i>59</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>News Correspondent</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Cleveland Plain Reader</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Chicago, Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Richard E. Kernan</i>					14. MOTHER'S MAIDEN NAME <i>Margaret Martin</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>471-09-8350</i>		17. INFORMANT <i>Dorothy J. Kernan</i>		Address <i>8600 16th Street Silver Spring, Md</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> <b>Bilateral subdural and subarachnoid hemorrhages</b> DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Bronchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>6-10-1964</i> , to <i>7-15-1966</i> , that (I) (we) last saw the deceased alive on <i>7-15-1966</i> , and that death occurred at <i>2:30 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>E. Clarence Rice</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7-15-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>E. Clarence Rice</i>					22d. ADDRESS <i>1150 Connecticut Ave., N.W., Washington, D.C. 20036</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 21, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Red Wing, Minn.</i>					
24. FUNERAL DIRECTOR <i>John B. Thomas Warner E. Humphrey, Inc.</i>					ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>JUL 18 1966</i>				
					25b. REGISTRAR'S SIGNATURE <i>Francis J. [Signature]</i>						

Bilateral subdural and  
 subarachnoid hemorrhages  
 and pneumothorax

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10163

## CERTIFICATE OF DEATH

10155

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		d. STREET ADDRESS <b>10201 Grosvenor Place</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mr. George Edward Kettering, Sr.</b>		4. DATE OF DEATH Month Day Year <b>July 22, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 -5-00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania US</b>
13. FATHER'S NAME <b>Mr. George E. Kettering</b>		14. MOTHER'S MAIDEN NAME <b>Sara C. Crusan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Army World War 1</b>		16. SOCIAL SECURITY NO. <b>579-52-5705</b>	
17. INFORMANT Address <b>Thelma P. Kettering: See Item #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> 4331 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Arrhythmia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>-</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>66</b> , to <b>July 21</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>July 21</b> , 19 <b>66</b> , and that death occurred at <b>1:50</b> A.M., from causes and on the date stated above.			
22a. SIGNATURE <b>R. H. Sandstrom</b>		22b. DATE SIGNED <b>7-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. H. Sandstrom MD</b>		22d. ADDRESS <b>7701 Carroll Ave Takoma Park, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-26-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>JUL 25 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10155

10155

35

Auto engine repair

Engine repair

Auto engine repair

on

10155



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10164

## CERTIFICATE OF DEATH

10156

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b -- -- d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5908 Namakagan Road</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5908 Namakagan Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>HENRY</b> First <b>F.</b> Middle <b>KIMBALL</b> Last		<b>4. DATE OF DEATH</b> Month <b>JULY</b> Day <b>21</b> Year <b>19 66</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5-8-1893</b>
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Banker &amp; Tax Consultant</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>William Henry Kimball</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Blanche Frankland</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>579-01-5212</b>	
<b>17. INFORMANT</b> <b>Mildred H. Limball - See Item No. 2</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>HYPERTENSION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>INSTANTANEOUS</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 1b.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State) <b>Washington, D.C.</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>JANUARY 19 1946</b> <b>to</b> <b>JULY 21 1966</b> <b>that (I) (we) last saw the deceased alive on</b> <b>JULY 20 1966</b> <b>and that death occurred at</b> <b>9:55 P.M.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Michael J. McInerney</b> M.D. <b>22c. PHYSICIAN'S NAME (Type)</b> <b>MICHAEL J. McINERNEY</b>		<b>22b. DATE SIGNED</b> <b>7-21-1966</b> <b>22d. ADDRESS</b> <b>916 - 19th St. Washington, D.C.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>7-25-1966</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Suitland, Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash. DC.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUL 25 1966</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10165

CERTIFICATE OF DEATH

10157

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>43 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> 15-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>7410 Brookville Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Snyder</b> Last <b>KING</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21 1892</b>
9. AGE (In years lost birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Altoona, Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Andrew Snyder</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>577-52-0002</b>		17. INFORMANT <b>ville Rd., Chevy Chase, Md.</b> <b>RADM Ogden D. King, USN, Ret. 7410 Brook-</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Stomach</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>13 DAYS</b> <b>20 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (b) (this hospital) attended the deceased from <b>June 15</b> , 19 <b>66</b> , to <b>July 28</b> , 19 <b>66</b> that (d) (we) last saw the deceased alive on <b>July 28</b> , 19 <b>66</b> , and that death occurred at <b>530 PM</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>Lindsay C. Getzen</b>		22b. DATE SIGNED <b>July 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lindsay C. Getzen, M. D.</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-1-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>
23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>		24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b> ADDRESS <b>5130 Wisconsin Ave., N. W. Washington, D. C.</b>	
25a. REC'D BY REGISTRAR DATE <b>AUG 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10157

10157

MINISTRY OF HEALTH

RECEIVED BY THE MINISTRY OF HEALTH

THE SECRETARY OF THE MINISTRY OF HEALTH

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

10157

1  
11  
M  
68  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10166									
10158									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring,					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last James Beverly King					4. DATE OF DEATH Month Day Year July 1, 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/25/21		9. AGE (In years last birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realty Specialist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Bagby R. King					14. MOTHER'S MAIDEN NAME Culena Thorne				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 44-11				
17. INFORMANT Mrs. Edyth M. King					Address 1605 Woodman Avenue Silver Spring, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute coronary artery thrombosis DUE TO (b) Myocardial infarction & failure. DUE TO (c) Coronary artery insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 2 hrs. - 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1966, to July 1, 1966, that (I) (we) last saw the deceased alive on July 1, 1966, and that death occurred at 12:10 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Ernest E. Harmon					22b. DATE SIGNED 1 July 66				
22c. PHYSICIAN'S NAME (Type) Ernest E. Harmon					22d. ADDRESS M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF July 5, 1966				
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.					23d. LOCATION (City, town or county) (State) Arlington, Va.				
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.					25a. REC'D BY REGISTRAR 8434 Georgia Ave. Silver Spring, Md.				
25b. REGISTRAR'S SIGNATURE Charles Judge					DATE JUL 6 1966				

10152



STATE OF NEW YORK  
IN SENATE  
January 10, 1907  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1906  
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS  
1907



10167

CERTIFICATE OF DEATH

10159

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
c. LENGTH OF STAY IN 1b <u>29 days</u>		d. STREET ADDRESS <u>801 Gregorio Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Estelle</u> Last <u>Kline</u>		4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/1927</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Webster Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Cogar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 54 7485</u>	
17. INFORMANT <u>Edythe M. Penahan</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cervical carcinoma (from Cervix uteri)</u> DUE TO (b) <u>171X</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>? months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <u>June 23, 1966</u> to <u>July 21, 1966</u> , that (I) <u>last</u> saw the deceased alive on <u>July 21, 1966</u> , and that death occurred at <u>4:18 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Gene H. Colter M.D.</u>		22b. DATE SIGNED <u>July 21, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE H. COLTER, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST SILVER SPRING MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>July 25, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Co., Md.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10153

10153

10153

*[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page.]*

FOR STATE  
HEALTH DEPT.

10168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10160

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>716 McNeil Lane</u>		d. STREET ADDRESS <u>15611 New Hampshire Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William Elmer Knight</u>		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-2-13</u>
		9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ralph X Knight</u>		14. MOTHER'S MAIDEN NAME <u>Jona Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-2648 7885</u>	
17. INFORMANT <u>Robert M. Knight</u>		Address <u>2197 Henderson Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute coronary thrombosis</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) <u>lost.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>July 10, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 13, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Episcopal Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Beltsville, Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glenn Carter</u> ADDRESS <u>8434 Georgia Ave.</u>		25a. REC'D BY REGISTRAR <u>JUL 14 1966</u>	
<u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10100

10101

UNITED STATES DEPARTMENT OF AGRICULTURE

10102

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "DEPARTMENT OF AGRICULTURE" are faintly visible.]*

*[Handwritten notes and signatures at the bottom of the page, including what appears to be a date "July 1910" and a signature.]*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10169

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10161

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>75-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN + HOSPITAL</u>				d. STREET ADDRESS <u>3121 BREXETON AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH ANTHONY KRUSZEWSKI</u>				4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-17-17</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>		11. IF UNDER 24 HRS. Hours <u>48</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AMERICAN BRIDGE CO</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburg Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH ANTHONY KRUSZEWSKI</u>				14. MOTHER'S MAIDEN NAME <u>STEPHANIE KOPICKI</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WORLD WAR II</u>		17. INFORMANT <u>DAUGHTER</u>		Address <u>MRS MARION McMERVEY TK-PK</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belren R. Read, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>July 9, 1966</u>	
EXAMINER'S NAME (Type) <u>BELREN R. READ, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>		Address (Street, city, town, or county) <u>254 Carroll St. N.W. Washington, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/13/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		23d. LOCATION (City or Town) (County) (State) <u>Pittsburg PENNA</u>	
24. FUNERAL DIRECTOR <u>John W. Walters</u>		ADDRESS <u>254 Carroll St. N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>JUL 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1000

1000

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Dr. Keap  
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10170					10162				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>8484 16th Street # 908</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>KARRY</b> First <b>NAI</b> Middle <b>KURLAND</b> Last			4. DATE OF DEATH <b>July,</b> Month <b>8</b> Day <b>1966</b> Year		9. AGE (In years last birthday) <b>78</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/15/88</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher (retired)</b>	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>David</b>				14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>579-03-7927</b>		17. INFORMANT <b>Sidney Levine</b> Address <b>2203 Mark Ct. S.S. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO (b) <b>Arteriosclerotic Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) this hospital attended the deceased from <b>June</b> , 19 <b>66</b> , to <b>July 8</b> , 19 <b>66</b> that (2) we last saw the deceased alive on <b>July 8</b> , 19 <b>66</b> , and that death occurred at <b>3:00</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Morton Shapiro</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/8/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Morton Shapiro</b>				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Gar.</b>			23d. LOCATION (City, town or county) (State) <b>Falls Ch., Va.</b>		
24. FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b> ADDRESS <b>3501-14th St. N.W. Wash. D.C.</b>				25a. REG'D BY REGISTRAR <b>JUL 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1018

0170

Long Street

Living

Long Street

Living

Living

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

Long Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MONTGOMERY											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10171											
10163											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b <i>1 year</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Olney</i>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Fairland Nursing Home</i>					d. STREET ADDRESS <i>15-1</i>						
3. NAME OF DECEASED (Type or print) First <i>Malcolm</i> Middle <i>D</i> Last <i>Lamborne</i>			4. DATE OF DEATH Month <i>July</i> Day <i>4</i> Year <i>19 66</i>								
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 17, 1885</i>		9. AGE (In years last birthday) <i>81</i> <i>years</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Newspaper writer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Evening Star</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Mobile, Ala.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13. FATHER'S NAME <i>Duncan Lamborne</i>					14. MOTHER'S MAIDEN NAME <i>Clara Morris</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Don R. Lamborne</i>			Address <i>Olney, Maryland</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia and Shock</i> <i>177X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Adenocarcinoma of Prostate</i> DUE TO (c) <i>1975</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I (this hospital) attended the deceased from <i>April, 1962</i> , to <i>7/4</i> , 19 <i>66</i> , that (I (we) last saw the deceased alive on <i>7/4</i> , 19 <i>66</i> , and that death occurred at <i>3:00</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>G. Lennard Gold</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>7/4/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>G. Lennard Gold</i>					22d. ADDRESS <i>8641-Colesville Rd. Silver Spring, Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 7, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Suitland, Maryland</i>				
24. FUNERAL DIRECTOR <i>C. Glen Carter</i> <i>Warner E. Pumphrey, Inc.</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10153

CERTIFICATE OF DEATH

STATE OF NEW YORK

IN SENATE, JANUARY 11, 1907.

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10153

10172

## CERTIFICATE OF DEATH

10164

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>20 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>99 Waples Mobile Home Estate</b>	
3. NAME OF DECEASED (Type or print) <b>Josephine Ann LA POINTE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1934</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Putnam, Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Pietro Gervasio</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Martini</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>042-28-5268</b>	
17. INFORMANT <b>Home Estates Fairfax, Virginia</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive pulmonary carcinomatosis, secondary to carcinoma breast</b> DUE TO (b) <b>Carcinoma breast metastatic to lung</b> DUE TO (c) <b>Carcinoma breast</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>July 9, 1966</b> , to <b>July 29, 1966</b> , that (2) (we) last saw the deceased alive on <b>July 29, 1966</b> , and that death occurred at <b>0700M</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Halbert E. Ashworth</b>		22b. DATE SIGNED <b>July 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Halbert E. Ashworth, M. D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial trans</b>		23b. DATE THEREOF <b>7/30/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Putnam, Connecticut</b>	
24. FUNERAL DIRECTOR <b>R. A. Pumphrey Funeral</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 2 1966</b>	
ADDRESS Home <b>7557 Wisconsin Ave., Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10101

10101

10101

(10101)

10101



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

10173

10165

1. PLACE OF DEATH a. COUNTY <b>Montgomery Co.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>1 yr. 8 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>				d. STREET ADDRESS <b>9280 Adelphi Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Morris</b>		First		Last <b>Lax</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12,</b> Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caus.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Dec. 14, 1888</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Haberdasher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (County & State, or foreign country) <b>AUSTRIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Max Lax</b>			
14. MOTHER'S MAIDEN NAME <b>unknown</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>			
16. SOCIAL SECURITY NO. <b>076-263990</b>				17. INFORMANT <b>Jay Zemel, 1010 Robroy Dr., Sil Spg., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> <b>Arteriosclerotic Cardio -</b> DUE TO (b) <b>Vascular and Arterial</b> DUE TO (c) <b>10 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 23, 1964</b> to <b>July 12, 1966</b> that (I) (we) last saw the deceased alive on <b>July 11, 1966</b> , and that death occurred at <b>7:50 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>William Brainin</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		22d. ADDRESS <b>6124 Central Ave, Capital Heights, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-13-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Va.</b>	
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		ADDRESS <b>4217 9th Street N.W.</b>		25a. REC'D BY REGISTRAR <b>JUL 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10165

10173

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

10165

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
10174														
10166														
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>75 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Shellman</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Route #2</b> d. STREET ADDRESS <b>Route #2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>Willie Fred Lay</b>					4. DATE OF DEATH Month Day Year <b>July 5 1966</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8 November 1896</b>		9. AGE (In years last birthday) <b>69</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								
13. FATHER'S NAME <b>Lawrence A. Lay</b>					14. MOTHER'S MAIDEN NAME <b>Nannie Couch</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 299X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Macroglobulinemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>2 years</b>														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>21 April</b> , 19 <b>66</b> , to <b>5 July</b> , 19 <b>66</b> , that <b>we</b> (we) last saw the deceased alive on <b>5 July</b> , 19 <b>66</b> , and that death occurred at <b>3:45 M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Herbert E. Kann, Jr., M.D.</b>					22b. DATE SIGNED <b>5 July 1966</b>									
22c. PHYSICIAN'S NAME (Type) <b>Herbert E. Kann, Jr., M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>			23b. DATE THEREOF <b>7/6/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rehoboth</b>		23d. LOCATION (City, town or county) (State) <b>Shellman, Georgia</b>							
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike</b> <b>Rockville, Maryland</b>					25a. REC'D BY REGISTRAR <b>JUL 8 1966</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

10160

Georgia

Montgomery

Shelton

75 days

Bethesda

Route 42

The Clinical Center, Bethesda, Maryland

July 5 66

July

Tree

Willie A

8 November 1896 69

Male White

U.S.A.

Georgia

Agriculture

Farmer

Hannie Couch

Lawrence A. Day

The Medical Records

Not available The Clinical Center, Bethesda, Maryland

--

6 weeks

Thrombosis

2 years

Microfilariaemia

July 5 66

July 5 66

21 April

3:45 P.M.

66

July 5

July 5 1966

The Clinical Center, National

Institute of Health, Bethesda, Maryland

Herbert M. Kahn, Jr., M.D.

Shelton, Georgia

Rebokat

7/5/66

Specimen received 12-13-66  
Microfilariaemia

10175

## CERTIFICATE OF DEATH

10167

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5400 Pooks Hill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Shirley Ann Le Blanc</u>		4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8, 1934</u>
9. AGE (In years last birthday) yrs. <u>31</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Bond</u>		14. MOTHER'S MAIDEN NAME <u>Viola Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>460-58-7919</u>	
17. INFORMANT <u>Husband - Harrell - home</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1750</u> <u>Carcinomatosis</u> DUE TO (b) <u>Pseudomucinous cystadenocarcinoma rt Ovary</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>65</u> to <u>PRESENT</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> , 19 <u>66</u> , and that death occurred at <u>10A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Fischer</u>		22b. DATE SIGNED <u>7/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. FISCHER</u>		22d. ADDRESS <u>50 W. Edmonston Dr., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>	23b. DATE THEREOF <u>7-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Upper Darby, Penna.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>JUL 7 1966</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10107

10173

8 38

400-2-712

Cardinalis

Isidus minime dytisciformis 11 Ovaris

10107



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>15-1</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>810 Burnt Mills Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>810 Burnt Mills Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Sherry Lee</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1887</b>
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of last year, or if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Moughan, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Sherry</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>James P. Lee (Same as # 2)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissection of aortic aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1939</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1939</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 7, 1966</b> , to <b>July 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 26, 1966</b> , and that death occurred at <b>8:00 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Blaine H. Eig</b>		22b. DATE SIGNED <b>July 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Blaine H. Eig</b>		22d. ADDRESS <b>8641 Colander Rd. Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Interment</b>		23b. DATE THEREOF <b>8/1/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Long Island National</b>		23d. LOCATION (City or Town) (County) (State) <b>Pinelawn, New York</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons 4739 Balt. Ave, Hyattsville, Md</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

James P. Lee ( Same as # 2 )

Unknown

Moughan, Ireland

U.S.A.

Patrick Sherry

House wife

Own Home

Female White

xx

May 16, 1887

79

July

29

66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10177

10169

<b>1. PLACE OF DEATH</b> a. COUNTY <div style="text-align: center; font-size: 1.2em;">Montgomery</div> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <div style="text-align: center; font-size: 1.2em;">D C</div> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Kensington</div>		c. LENGTH OF STAY IN 16 <div style="text-align: center; font-size: 1.2em;">Washington</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">Kensington Gardens</div>		d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">47-3</div>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="text-align: center; font-size: 1.2em;">CHARLES E. LeFOE</div>		<b>4. DATE OF DEATH</b> <div style="text-align: center; font-size: 1.2em;">July. 3. 1966</div>	
<b>5. SEX</b> <div style="text-align: center; font-size: 1.2em;">Male</div>	<b>6. COLOR OR RACE</b> <div style="text-align: center; font-size: 1.2em;">White</div>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <div style="text-align: center; font-size: 1.2em;">WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>	<b>8. DATE OF BIRTH</b> <div style="text-align: center; font-size: 1.2em;">Oct. 26. 1884</div>
<b>9. AGE</b> (In years last birthday) <div style="text-align: center; font-size: 1.2em;">81 yrs.</div>		<b>10. IF UNDER 1 YEAR</b> Months Days	<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">Ret Attorney</div>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <div style="text-align: center; font-size: 1.2em;">Railroad</div>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <div style="text-align: center; font-size: 1.2em;">Virginia</div>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <div style="text-align: center; font-size: 1.2em;">Thomas B. LeFoe</div>		<b>14. MOTHER'S MAIDEN NAME</b> <div style="text-align: center; font-size: 1.2em;">Wilmina Green</div>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center; font-size: 1.2em;">No No</div>		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>IMMEDIATE CAUSE (a)</b>  <div style="text-align: center; font-size: 1.5em;">331X</div> </div> <div style="width: 45%;"> <b>331X</b>            DUE TO  <div style="text-align: center; font-size: 1.5em;">cerebral vascular accident</div> </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </div> <div style="width: 45%;"> <b>(b)</b>            DUE TO  <div style="text-align: center; font-size: 1.5em;">generalized arteriosclerosis</div> </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>(c)</b> </div> <div style="width: 45%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <div style="text-align: center; font-size: 1.5em;">3 days 10 yrs</div> </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <div style="text-align: center; font-size: 1.2em;">19</div>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from May 1962 to July 3, 1966, that (I) (we) last saw the deceased alive on July 3, 1966, and that death occurred at 4:15 P.M. from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <div style="text-align: center; font-size: 1.5em;">[Signature]</div>		<b>22b. DATE SIGNED</b> <div style="text-align: center; font-size: 1.2em;">7/3/66</div>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <div style="text-align: center; font-size: 1.2em;">1615 Kreuzburg</div>		<b>22d. ADDRESS</b> <div style="text-align: center; font-size: 1.2em;">7152 16th Ave Wash DC</div>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <div style="text-align: center; font-size: 1.2em;">Burial</div>		<b>23b. DATE THEREOF</b> <div style="text-align: center; font-size: 1.2em;">7.6.1966</div>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center; font-size: 1.2em;">Glenwood Cemetery</div>		<b>23d. LOCATION (City or Town) (County) (State)</b> <div style="text-align: center; font-size: 1.2em;">Washington D C</div>	
<b>24. FUNERAL DIRECTOR</b> <div style="text-align: center; font-size: 1.2em;">Lee Funeral Home 300.4th st N E</div>		<b>25a. REC'D BY REGISTRAR</b> DATE <div style="text-align: center; font-size: 1.2em;">JUL 8 1966</div>	
<b>25b. REGISTRAR'S SIGNATURE</b> <div style="text-align: center; font-size: 1.5em;">[Signature]</div>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1997年10月

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10178

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10170

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adamstown</u> 10-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 355 at Old Balto. Rd.</u>		d. STREET ADDRESS <u>Route I</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES RUSSELL LENHART</u>		4. DATE OF DEATH Month <u>7</u> - Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/26</u> 40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Equip. Oper.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Constr.</u>	
11. BIRTHPLACE (State or foreign country) <u>Flint Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Lewis D. Lenhart</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Hause</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>219-12-2034</u>	
17. INFORMANT <u>Mrs. Ruth Lenhart, Monrovia, Md.</u>		Address <u>21770</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury of Head</u> DUE TO (b) <u>with exsanguination.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II.) <u>Dump truck bed elevated, collapsed on deceased's head.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:00 a.m. 7-15 1966</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Clarksburg</u> (County) <u>Montgomery</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Charles Judge</u> Address (Street, City, Town or County) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/21/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Ft. Myer, Va.</u>	
24. FUNERAL DIRECTOR <u>Frank R. Smith, Jr.</u> <u>M. R. Etchison &amp; Son, Frederick, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 22 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10110

RECEIVED

10110

10110

Handwritten notes and signatures, including "James H. [illegible]" and "John [illegible]".

Handwritten notes and signatures, including "James H. [illegible]" and "John [illegible]".

Handwritten notes and signatures, including "James H. [illegible]" and "John [illegible]".



CERTIFICATE OF DEATH

10180

10172

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>11 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>8300 Flower Ave, Apt. 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MR. Byron Henderson Lewis</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-89</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Lewis</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Chart</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 5702 DUE TO <u>Post-operative Renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Presenting Thrombosis &amp; Gangrene of Celiac</u> (c) <u>terminal disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6/24/66 to 7/7/66</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> , 19 <u>66</u> , to <u>7/7</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>7-7</u> 19 <u>66</u> , and that death occurred at <u>3:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur F. Passarelli</u>				22b. DATE SIGNED <u>7-7-66</u>		22c. PHYSICIAN'S NAME (Type) <u>ARTHUR F. PASSARELLI</u>	
22d. ADDRESS <u>5806 SARGENT RD CHILLUM MD</u>				22e. REC'D BY REGISTRAR <u>W. Danby Baptist</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>W. Danby Baptist</u>		23d. LOCATION (City or Town) (County) (State) <u>W. Danby, N.Y.</u>	
24. FUNERAL DIRECTOR <u>W.W. Chamberco</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10135

STATE OF DEATH

0120

10135 0120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10173

10171

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>		d. STREET ADDRESS <u>6515 16th St N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Isabel Martin</u> First <u>Lewis</u> Middle <u>xxx</u> Last		4. DATE OF DEATH <u>July</u> Month <u>31</u> Day <u>1966</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1881</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from U.S. Govt. Astronomer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAINE</u>	
11. BIRTHPLACE (State or foreign country) <u>MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Martin</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Manson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>579-60-6204</u>	
17. INFORMANT <u>Raymond W. Lewis</u>		Address <u>6515 16th Street, N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Collapse</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>Generalized Arteriosclerosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins</u> <u>10 yrs.</u> <u>12 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> 19 <u>55</u> to <u>7/31</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> 19 <u>66</u> and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Everett</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		22d. ADDRESS <u>9400 Conn. Ave. Kensington</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 3, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10181

## CERTIFICATE OF DEATH

10173

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ o. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>56 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> <b>83-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>507 N. Norwood St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>Hayden</b> Last <b>Lewis</b>				4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 Feb 1904</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Paris, Texas</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John William Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Edmonia Turman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>1927-1955</b>		16. SOCIAL SECURITY NO. <b>230-50-7390</b>		17. INFORMANT <b>Dora C. Lewis</b>		18. ADDRESS <b>507 N. Norwood St. Arlington, Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease / congestive heart failure</b> 1950 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (a) <b>Adenocarcinoma of the adrenal glands</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Disseminated carcinoma / Arteriosclerotic heart disease</b> <b>1 yr.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>31 May</b> , 1966, to <b>25 July</b> , 1966, that (2) (we) last saw the deceased alive on <b>25 July</b> , 1966, and that death occurred at <b>7:00 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>R. H. Easterday</b>				22b. DATE SIGNED <b>Jul. 27, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>R. H. Easterday, M. D.</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>S.H. Hines Co.</b> ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10153

RECEIVED

10153

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10182

10174

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PENNINGTON</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL HALL SANITARIUM</u>				d. STREET ADDRESS <u>8450 PINEY BRANCH COURT</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH HAGERTY LOCKYER</u>				4. DATE OF DEATH Month Day Year <u>July 18 1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 10, 1893</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HAGERTY</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE LONG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Wm. A. Lockyer - 8450 Piney Branch Ct. SIL SPR. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Pulmonary embolism (thrombosis)</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Atherosclerosis generalized</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-28</u> , 1966 to <u>July 17</u> , 1966, that (I) (we) last saw the deceased alive on <u>July 6</u> , 1966, and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.				22b. DATE SIGNED <u>7/19/1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>				22d. ADDRESS <u>1106 SPRING ST., SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>		23d. LOCATION (City, town or county) (State) <u>SUITLAND RD - FR. GEO. CO. MD.</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC., SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>JUL 22 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10134

10135

10183

## CERTIFICATE OF DEATH

10175

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sant Hospital</u>		e. STREET ADDRESS <u>605 Nolley Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Myrtle Logan</u>		4. DATE OF DEATH <u>7 3 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburgh, Pa</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. John Brown</u>		14. MOTHER'S MAIDEN NAME <u>Anna B. Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4201</u>	
17. INFORMANT <u>Mrs. Wm. Terrett</u>		Address <u>as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>4201</u> DUE TO (c) <u>Diabetes mellitus + Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus + Congestive Heart Failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>63</u> , to <u>July 3</u> , 19 <u>66</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>July 1</u> , 19 <u>66</u> , and that death occurred at <u>10:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u>		22b. DATE SIGNED <u>7/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS <u>1106 Spring Street, Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-5-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Maryland</u>
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JUL 7 1966</u>	
ADDRESS <u>4308 Suitland Rd Suitland Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

55191

6875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10184					10176						
Item 9 Film 6378 7/21/66 mh											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase, Maryland</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5214 Western Ave. Chd. Md.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>LESLIE</u> Middle <u>LORE</u> Last <u>LORE</u>					4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-1880</u>		9. AGE (In years last birthday) <u>75</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Ethan Lore</u>					14. MOTHER'S MAIDEN NAME <u>Louivisa Campbell</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>577126635</u>						
17. INFORMANT <u>Elinor L. Early</u>					Address <u>5214 Western Ave. Cherry Chase, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4200 DUE TO <u>Complete Heart Block</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Advanced Arteriosclerotic Heart Disease</u> (b) <u>3 years</u> (c) <u>10 years</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>11/11, 1957</u> to <u>7/9, 1966</u> , that (I) (we) last saw the deceased alive on <u>6/29, 1966</u> , and that death occurred at <u>12:54</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank Y. Jagers Jr.</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/9/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>FRANK Y JAGGERS JR</u>					22d. ADDRESS <u>5707 WISCONSIN AVE</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 12 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Millville New Jersey</u>				
24. FUNERAL DIRECTOR <u>Cherry Chase</u>					ADDRESS <u>5101 WISC Ave</u>		25a. REC'D BY REGISTRAR <u>J Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		
DATE <u>JUL 11 1966</u>											



10150

RECEIVED

10150

Only those persons who are  
born in the United States  
or born abroad of American  
parents are citizens of the  
United States.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																					
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9824 Rosensteel Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Layton</u> Middle <u>Earl</u> Last <u>Loudermilk</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>14</u> Year <u>1966</u>		<b>5. SEX</b> <u>Male</u>			<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>											
<b>8. DATE OF BIRTH</b> <u>July 4, 1881</u>			<b>9. AGE</b> (In years last birthday) <u>85</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret. Supervisor</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Road Construction</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>13. FATHER'S NAME</b> <u>Washington Loudermilk</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Crawford</u>																
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>228-05-3047</u>		<b>17. INFORMANT</b> <u>Edith L. Carter</u>		<b>Address</b> <u>9824 Rosensteel Silver Spring, Md.</u>														
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> (b) <u>Congestive Heart Failure</u> (c) <u>Generalized Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 years</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>									<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)														
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 1, 1965</u> <b>to</b> <u>July 14, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>July 14, 1966</u> <b>and that death occurred at</b> <u>6 A.M.</u> <b>from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <u>John J. Curry</u>										<b>22b. DATE SIGNED</b> <u>7/14/66</u>											
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>John J. Curry</u>					<b>22d. ADDRESS</b> <u>10120 Ga. Ave., S. S., Md.</u>																
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>July 16, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Glen Burnie Maryland</u>														
<b>24. FUNERAL DIRECTOR</b> <u>Clark E. Wisor</u>					<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>		<b>25b. REGISTRAR'S SIGNATURE</b>														
<u>Warner E. Pumphrey, Inc.</u>					<u>8434 Georgia Ave. Silver Spring, Md.</u>		<b>DATE</b> <u>JUL 18 1966</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

DR. REAR NOTIFIED AND APPROVED 7/18/66

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 2 Film 6379 7/26/66 mh											
10186 CERTIFICATE OF DEATH 10178											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Maryland</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH DC</u> Washington <u>47-9</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen. &amp; Hosp.</u>						d. STREET ADDRESS <u>425 Jefferson St. NW</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Elmer</u> Last <u>Lystinger</u>						4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-13-83</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>California</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry C.</u>						14. MOTHER'S MAIDEN NAME <u>Emma Hulbot</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>263-76-12457</u>		17. INFORMANT <u>Hospital Records</u>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>493 X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> 3 to 4 <u>Days</u> DUE TO (b) <u>Bacteria &amp; aspiration</u> 3 to 4 <u>Days</u> DUE TO (c) <u>Fractured left hip</u> 24 <u>Days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(a)) <u>past CVA with residual L hemiparesis, urinary tract infection</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell while walking</u>							
20c. TIME OF INJURY Month, Day, Year <u>8</u> Hour a.m. <u>6</u> 22 1966 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) (County) (State) <u>Beltsville PG Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>66</u> , to <u>7/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/16</u> , 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Kenneth C. Cuy</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/16/66</u>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 19-1966</u>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>				23d. LOCATION (City or town) (County) (State) <u>Radonburg P.D. Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>						ADDRESS <u>254 Carroll St. N.W.</u>		25a. REC'D BY REGISTRAR <u>DATE JUL-19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

5101

28103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10187					10179				
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5125 Georgia Ave. N.W.</u>				
3. NAME OF DECEASED (Type or print) <u>Josephine</u> First Middle Last <u>Maciulla</u>					4. DATE OF DEATH Month Day Year <u>July 5 1966</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 25 1891</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GIACOMO DI LORENZO</u>					14. MOTHER'S MAIDEN NAME <u>MARIA RIINA</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>2A B C, d ABOVE</u>		17. INFORMANT <u>DR. LOUIS MACIULLA</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> <u>4201</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Coronary &amp; Hypertensive Cardiovascular Disease</u> (c) <u>years</u> INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>1 day</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1966</u> , to <u>July 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>7/5 1966</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>G. Lennard Gold</u>					22b. DATE SIGNED <u>7/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold, M.D.</u>		
22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8 JULY 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, DC.</u>			
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME INC. 7400 GEORGIA AVE. N.W.</u>					25a. REC'D BY REGISTRAR <u>at 2:00 PM</u> DATE <u>JUL 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

10131

10131



G. Leonard Gold, M.D.

8041 Coleville Rd., Silver Spring, Md.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>10188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10180</div>										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>5/31/59 TO 7/4/66</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hakoma PARK. MD 15-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Garden Nursing Home</u>					d. STREET ADDRESS <u>415-Browning St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <u>MAY</u>		Middle <u>L</u>		Last <u>Marschalk</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1966</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT-27-1883</u>		9. AGE (In years last birthday) <u>82</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>David P. Snowhill</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Russell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>Henry E. Marschalk</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>334 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>infection.</u> DUE TO (c) <u>Cerebral Arterio Sclerosis -</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days -</u> <u>Months.</u> <u>Years.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/15/66</u> Address (Street, city, town, or county)										
ACTUAL SIGNATURE <u>John G. Bell</u>		22. DATE SIGNED								
EXAMINER'S NAME (Type)										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
<u>Cremation</u>		<u>July 16, 1966</u>		<u>Cedar Hill Cemetery</u>		<u>Suitland, Md.</u>				
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>					ADDRESS <u>4308 Suitland Rd. Suitland, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10150

GENERAL EXAMINER'S CERTIFICATE OF DEATH

1918

THE STATE OF TEXAS  
COUNTY OF DALLAS

*[Faint, mostly illegible text follows, likely containing the details of the death certificate.]*

*[Faint, mostly illegible text continues on the right side of the page.]*

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>327 Lincoln, Rockville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>50 yrs.</u>				d. STREET ADDRESS <u>327 Lincoln Ave</u>			
3. NAME OF DECEASED (Type or print) <u>JANETT Davis</u> First Middle Last				4. DATE OF DEATH <u>July 22 1966</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25, 1874</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Katay Davis</u> Address <u>Same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystectomy, Appendectomy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19....., to <u>7-22</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>7-21</u> , 19 <u>66</u> , and that death occurred at <u>4P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Oliver E. Jackson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-23-66</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>202 Martin Ln, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE THEREOF <u>7-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>JUL 26 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1911

1911

FOR STATE  
HEALTH DEPT.

10190

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10182

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY in 1b <i>16-2</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San &amp; Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. George</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chillum</i> d. STREET ADDRESS <i>6003-10th Place</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Julia Helen Martin</i>		4. DATE OF DEATH Month <i>7</i> Day <i>26</i> Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-26-13</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <i>53</i>
11. BIRTHPLACE (State or foreign country) <i>Columbus, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frank Simpson</i>		14. MOTHER'S MAIDEN NAME <i>Mauda Johnson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>309-10-1147</i>	
17. INFORMANT <i>James S. Martin</i>		Address <i>6003-10-Pl Hyattsville</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination due to</i> 9777x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>suicidal laceration of neck</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Deceased cut her throat after swallowing household ammonia</i>	
20c. TIME OF INJURY Month, Day, Year <i>7:30 a.m. 7-26 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Chillum Pr. George Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Belden R. Reap M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county) <i>Washington</i>	
22. DATE SIGNED <i>7/27/1966</i>			
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>July 29-1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	23d. LOCATION (City or Town) (County) (State) <i>Arlington Va.</i>
24. FUNERAL DIRECTOR <i>Arthur Weller, 254 Canal St. N.W. Wash DC</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 29 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10125

(1)



10191

## CERTIFICATE OF DEATH

10183

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN lb <b>1 mo. 2 wks.</b>		d. STREET ADDRESS <b>2003 Virginia Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bernice Juanita May</b>		4. DATE OF DEATH Month Day Year <b>July 9 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 6 1911</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Moorehead, Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>W. H. Onstine Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mable Pierce</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>501-05-3579</b>	
17. INFORMANT <b>Leo G. May</b>		<b>2003 Virginia Ave Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure associated with Cirrhosis of the Liver.</b> DUE TO <b>Liver.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from <b>May 24</b> , 19 <b>66</b> , to <b>July 9</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>July 9</b> , 19 <b>66</b> , and that death occurred at <b>2:50 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. Zimmerman</b>		22b. DATE SIGNED <b>July 9 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Zimmerman, LT MC USN</b>		22d. ADDRESS <b>U. S. NAVAL HOSPITAL, BETHESDA, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>7/13/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON VIRGINIA</b>
24. FUNERAL DIRECTOR <b>Rouzer Funeral Home Hagerstown, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1953

MINISTRY OF DEFENSE

1953

Washington

Department

Department

Department

Department

Department

2000 Virginia Ave

Department

U.S. Naval Institute, Baltimore, Maryland

July

July

Department

Department

U.S. Navy

U.S. Navy

U.S. Navy

Department

Department

Department

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Greer</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>136 Spring Street</b>	
3. NAME OF DECEASED (Type or print) <b>Hubert DeWitt Mayfield</b>		4. DATE OF DEATH <b>July 15 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 July 1908</b>
9. AGE (In years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building Const.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Mayfield</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Parrett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>251-07-7730</b>	
17. INFORMANT <b>Clinical Center</b>		Address <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe aortic regurgitation</b> DUE TO (c) <b>Bronchogenic cancer?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 June</b> , 1966, to <b>15 July</b> , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>15 July</b> , 1966, and that death occurred at <b>10:55</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William W. Parnley</b>		22b. DATE SIGNED <b>15 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William W. Parnley, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>7/19/66</b>		23b. DATE THEREOF <b>7/19/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery Greer, SC</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>John T. Rhodes</b>		ADDRESS <b>3015-14 St. NE</b>	
25a. REC'D BY REGISTRAR <b>JUL 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1914

South Carolina

Montgomery

1914

10 days

Notman

150 Spring Street

The Clinical Center, Bethesda, Md.

12 68

July

Mayfield

Robert

Robert

57

19 July 1908

Neuro

Male

South Carolina

Building Center

Prickly

Little Point

Henry Mayfield

Clinical Center

Medical Records

251-07-7750

NO

Immediate

Cardiac arrhythmia

15 years

Severe cardiac degeneration

1 year

Bronchogenic cancer

X

12 68

15 July

10:55

19 June

68

15 July

X

A.M.

15 July 1908

The Clinical Center, National

Institute of Health, Bethesda, Md.

William W. Parney, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

10193

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10185

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN lb <u>1 hr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7825 Overhill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>ALton C. McAllister</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/1907</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stock Brokerage</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emuel A. McAllister</u>		14. MOTHER'S MAIDEN NAME <u>Annie D. Jette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-12-7722</u>	
17. INFORMANT <u>Same as Item 2</u>		Address <u>Mrs. Mildred F. McAllister-Wife</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Occlusion.</u> DUE TO (c) <u>Coronary Arteriosclerosis -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hr.</u> <u>8 hr.</u> <u>Years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/4/66</u>		22. DATE SIGNED	
Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/6/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>JUL 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1000

1000

STATE OF NEW YORK

IN SENATE

1892

1892

Block Station

Samuel A. Richardson

Annie C. Jones

577-13-1322, Mrs. William W. Allen - wife

1892

1892

1892

1892

1892

Robert A. Richardson



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
c. LENGTH OF STAY IN lb. <u>147.</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11617 Regency Dr.</u>		d. STREET ADDRESS <u>11617 Regency Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>GREGG HARPER McCLURG</u>		4. DATE OF DEATH <u>July 9 1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/1910</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>DIST. OF COL</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HARPER G. McCLURG</u>	
14. MOTHER'S MAIDEN NAME <u>MARY SHALL ENBERGER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>—</u> Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arterio Sclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 m.</u> <u>Years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>—</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>7/10/66</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>7-11-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PEDAR HILL CREMATORY</u>	23d. LOCATION (City or Town) (County) (State) <u>SUTLAND, MD</u>
24. FUNERAL DIRECTOR <u>Joseph Gawkers Sons</u>		ADDRESS <u>WASH., D.C.</u>	
25a. REC'D BY REGISTRAR <u>JUL 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10186

UNITED STATES DEPARTMENT OF AGRICULTURE

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

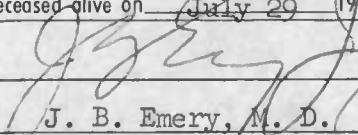

1918

1918

10195

## CERTIFICATE OF DEATH

10187

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b> <b>15-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>8315 Brook Lane, Whitehall/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Kiernan</b> Last <b>MCCRACKEN</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1888</b>		9. AGE (In years last birthday) yts. <b>78</b>		IF UNDER 1 YEAR Months <b>29</b> Days <b>19</b> Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civilian Emp. U. S.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Norfolk, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Kiernan</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. McPherson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>226 70 0887</b>		17. INFORMANT <b>Bethesda,</b> Address <b>Md.</b> <b>Mr. James K. McCracken, 9211 Holly Oak Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction secondary to</b> DUE TO <b>coronary arteriosclerosis and thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>July 11, 19 66</b> , to <b>July 29, 19 66</b> that <del>XX</del> (we) last saw the deceased alive on <b>July 29, 19 66</b> , and that death occurred at <b>1202 P</b> M, from causes on and on the date stated above.							
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>29 July 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. B. Emery, M. D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1 Aug. 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b> ADDRESS <b>5130 Wisconsin Ave., N.W., Washington, D. C.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 4 1966</b>		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10153

RECEIVED

10153

10153		RECEIVED		10153	
[Faint, illegible text across the top of the form]					
[Faint, illegible text across the middle of the form]					
[Faint, illegible text across the bottom of the form]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10196

CERTIFICATE OF DEATH

10188

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM</u>		d. STREET ADDRESS <u>4533 38th St.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>McFollin</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891</u> <u>10-22-90</u>
9. AGE (In years last birthday) <u>76 7/4</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Harrison McFollin</u>		14. MOTHER'S MAIDEN NAME <u>Ida Chamberlain</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-16-0823A</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis + hypertension</u> (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-7</u> , 19 <u>66</u> , to <u>7-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-21</u> , 19 <u>66</u> , and that death occurred at <u>12:50</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u>		22b. DATE SIGNED <u>7/21/1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22d. ADDRESS <u>831 Univ. Blvd. E. Silver Sp. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/26/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NAT'L Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co - Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 25 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10189									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Roaring Spring</b> 75.3				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN IB <b>8 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Roaring Spring</b> 75.3			d. STREET ADDRESS <b>100 Spang Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Joseph Mentzer</b>			4. DATE OF DEATH Month Day Year <b>July 27 1966</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>24 February 1915</b>		9. AGE (In years last birthday) <b>51</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John O. Mentzer</b>				14. MOTHER'S MAIDEN NAME <b>Ella Mae Loose</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>171-07-3838</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b> 20014					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myelocytic leukemia in blastic crisis</b> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myelocytic leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral lower lobe pneumonia - 8 days</b> <b>Generalized hemorrhagic diathesis secondary to thrombocytopenia, 7 days</b>								INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>2 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 19, 1966</b> , to <b>July 27, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 27, 1966</b> , and that death occurred at <b>9:40 M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Martin H. Cohen</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>July 27, 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>Martin H Cohen, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/30/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Martinsburg, Pa</b>			
24. FUNERAL DIRECTOR <b>John C. Bolger F.D.</b>		ADDRESS <b>Martinsburg Pa</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

12104

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10198

10190

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi Park</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium - Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi, Maryland 16-2</u> d. STREET ADDRESS <u>18 METZEROTT Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HAROLD (NMN) MESIBOV</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>7 30 1966</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4/16/14</u>		<b>9. AGE</b> (In years last birthday) <u>52 yrs.</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SPECIAL AGENT Dept. of Agricul.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NEW YORK CITY</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>MR. DAVID MESIBOV</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>RUTH Goldstein</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Adelphi, Md</u> <u>MRS. Rhoda Mesibov 18 METZEROTT Rd.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 YRS</u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Edgar H. Levin</u>			<b>22b. DATE SIGNED</b> <u>7/31/66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>EDGAR H. LEVIN</u>		
<b>22d. ADDRESS</b> <u>8218 Wisconsin Ave., Bethesda</u>			<b>22e. REC'D BY REGISTRAR</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8/1/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wt. Ararat Cemetery</u>			
<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Farmdale, L.I. N.Y.</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>13. Hanzanovsky &amp; Sons</u> <u>Wash. D.C.</u>					
<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>6 WEEKS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>UNIVERSITY NURSING HOME</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ADELPHI</b> d. STREET ADDRESS <b>9305 20TH AVE., APT. 102</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY FLORENCE MESS</b>			4. DATE OF DEATH Month Day Year <b>7 11 1966</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUC</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/21/1888</b>		9. AGE (in years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>DENTISTRY</b>			11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL MESS</b>					14. MOTHER'S MAIDEN NAME <b>ANNA KLOBB</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> <b>YES</b>			16. SOCIAL SECURITY NO. <b>W.W.I</b>		17. INFORMANT <b>Mrs. Edna D. Mess. (same as #2)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OSTEOPOROSIS SPINE WITH COMPRESSION FRACTURES</b>									INTERVAL BETWEEN ONSET AND DEATH <b>5 MINUTES</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>EARLY</b> , 19 <b>63</b> , to <b>JULY 11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>JULY 11</b> , 19 <b>66</b> , and that death occurred at <b>9:20</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>James A. Roberts</b>					22b. DATE SIGNED <b>JULY 11, 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>JAMES A. ROBERTS</b>					22d. ADDRESS <b>8907 GEO. AVE. SILVER SPRING, M.D.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>July 14-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Anne's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Prince George's Md.</b>			
24. FUNERAL DIRECTOR <b>J. Arthur Walters, 254 Carroll St N.W. Wash D.C.</b>						25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
DATE <b>JUL 15 1966</b>									





10200

CERTIFICATE OF DEATH

10192

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hgattsville</u>	
c. LENGTH OF STAY IN 1b <u>1 mo. 21 days</u>		d. STREET ADDRESS <u>1805 Fox St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>C. Elyse</u> First <u>Miller</u> Middle <u>H</u> Last <u>Miller</u>		4. DATE OF DEATH <u>July</u> Month <u>1</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/09</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Adm. Assistance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Columbus Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Carl Miller</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>275-01-4508</u>	
17. INFORMANT <u>V.R. Retallick</u>		Address <u>509 E. Warren St. Lebanon Ohio</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Adenocarcinoma, Colon</u> DUE TO (c) <u>1538</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>7-1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/27</u> 19 <u>66</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>DeWitt E. DeLawter</u>		22b. DATE SIGNED <u>July 1, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLawter</u>		22d. ADDRESS <u>8025 Aberdeen Rd Bethesda Md</u>	
23a. BURIAL, CREMATION, REMEMORIAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 5, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Columbus, Ohio</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
26. ADDRESS <u>434 Ga. Avenue Silver Spring, Md.</u>		27. DATE <u>JUL 5 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10138

CERTIFICATE OF DEATH

10138

Caroline

Abundant, Colon

10138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10201

10193

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7514 Newmarket Drive</b>				d. STREET ADDRESS <b>7514 Newmarket Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>M.</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>16</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1884</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Weston, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Thomas H. Miller - Same as Item #2-SON</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <b>with myocardial Failure</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture Rt. Hip sustained Sept 1964.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b></b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1959</b> to <b>16 July 1966</b> , that (I) (we) last saw the deceased alive on <b>14 July 1966</b> and that death occurred on <b>10 July 1966</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>A. H. Richwine</b>				22b. DATE SIGNED <b>1966</b>			
22c. PHYSICIAN'S NAME (Typed) <b>A. H. RICHWINE</b>				22d. ADDRESS <b>522 WESTERN AVE CHERRY CHASE, 15, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/19/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Silver Spring Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>				25a. REC'D BY REGISTRAR <b>JUL 19 1966</b>			
ADDRESS <b>Bethesda, Maryland</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10193  
 MONTGOMERY  
 MARYLAND  
 Bethesda  
 751 Newmarket Drive  
 Bethesda  
 M. MILLER  
 JULY 18 88  
 April 7, 1984  
 3 3  
 White  
 Homeville  
 Unknown  
 Unknown  
 Thomas H. Miller - some as item 42-301  
 10193  
 MONTGOMERY  
 MARYLAND  
 Bethesda  
 751 Newmarket Drive  
 Bethesda  
 M. MILLER  
 JULY 18 88  
 April 7, 1984  
 3 3  
 White  
 Homeville  
 Unknown  
 Unknown  
 Thomas H. Miller - some as item 42-301  
 10193  
 MONTGOMERY  
 MARYLAND  
 Bethesda  
 751 Newmarket Drive  
 Bethesda  
 M. MILLER  
 JULY 18 88  
 April 7, 1984  
 3 3  
 White  
 Homeville  
 Unknown  
 Unknown  
 Thomas H. Miller - some as item 42-301

CERTIFICATE OF DEATH

10202

10194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park - 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <del>XXXX</del> <u>7103 Maple Avenue</u>		d. STREET ADDRESS <u>7103 Maple Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Jessie Louise Miller</u>		4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July Dec 15, 1900</u> 65 yrs.
9. AGE (In years last birthday) <u>65</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James McElfatich</u>		14. MOTHER'S MAIDEN NAME <u>Lena C Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>XXXX-XX-XXXX</u>	
17. INFORMANT <u>James R. Miller</u>		Address <u>7103 Maple Avenue</u> <u>Jakoma Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u> 443X DUE TO (b) <u>Chronic Myocarditis &amp; Hypertension</u> DUE TO (c) <u>1 day</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/6/65</u> , 19 <u>65</u> , to <u>7/11/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3 months ago</u> , and that death occurred at <u>4 p.m.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Howard T. Moise</u>		22b. DATE SIGNED <u>7/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T. Moise</u>		22d. ADDRESS <u>2030 Carroll Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 14, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Glenn Carter</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 14 1966</u>	
ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Corvairs Off. of Health City & State of Md. by Telephone



40:01

507



10203

## CERTIFICATE OF DEATH

10195

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>22 hrs-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>7701 COYUGA AVE</u>	
3. NAME OF DECEASED (Type or print) <u>MYRTLE MOHAGEN</u>		4. DATE OF DEATH <u>JULY 11 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1904</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASS PERSONNEL DIR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NORTH DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHRISTIAN MOHAGEN</u>		14. MOTHER'S MAIDEN NAME <u>ELISE WARLOF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>322-380360</u>	
17. INFORMANT <u>Sister - Verna Mohagen</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1750 circulatory collapse (hemorrhage)</u> DUE TO (b) <u>carcinomatosis</u> DUE TO (c) <u>adeno carcinoma ovary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1-yr</u> <u>2+ yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>D.A.A.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAR, 1966</u> , to <u>7/11, 1966</u> , that (I) (we) last saw the deceased alive on <u>date 7/10/1966</u> , and that death occurred at <u>9 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles J. Savarese, Jr. M.D.</u>		22b. DATE SIGNED <u>7/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, JR. MD.</u>		22d. ADDRESS <u>11125 McMillan PIKE ROCKVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		23b. DATE THEREOF <u>7/12/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grafton Lutheran Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington Co. N. Dakota</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>JUL 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Savarese</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

10195

CENTRAL CO. OF PA.

10195

10195

Robert A. Humphrey, Business Manager, 10195  
Union Township, 10195  
Union Township, 10195

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10204

## CERTIFICATE OF DEATH

10196

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>15 - 1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
3. NAME OF DECEASED (Type or print) <b>Orlando</b> First Middle Last <b>Moncure</b>		4. DATE OF DEATH Month Day Year <b>July 26 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1872</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>1 13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad post.clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RR</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown St. Leger Moncure</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Lucy Olever</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>John Moncure-1337 Grandin Ave. Rockv, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) <b>2/8h.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 17/25/66</b> to <b>July 26 19 66</b> , that (I) (we) last saw the deceased alive on <b>7/25/66</b> , and that death occurred at <b>7:20</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Stephen F. Verges</b>		22b. DATE SIGNED <b>7/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen F. Verges</b>		22d. ADDRESS <b>5721 - Prosser Lane</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/29/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Aquia Church Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Stafford County Virginia</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 29 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10196

COMPONENT OF DEATH

10196

1-13

Unknown to Death Unknown to Death

John Monahan-1937 Graham Ave. 10196

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

Unknown to Death Unknown to Death

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10205

10197

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN 1b <u>YEAR</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1311 GRANDIN AVE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>MONTGOMERY</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>1131 GRANDIN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>EMMA BARNES MOORE</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>JULY 10 1966</u> Month Day Year				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>DEC 23, 1875</u>	<b>9. AGE</b> (In years last birthday) <u>90</u> yrs. If UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS.: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>WILLIAM BARNES</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNIE MITTEN</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service) _____ <b>17. INFORMANT</b> _____ Address _____				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO (b) <u>single anteriorly cardiovascular disease</u> (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 15, 1966</u> <b>to</b> <u>July 10, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>July 8, 1966</u> , <b>and that death occurred at</b> <u>5 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>W. A. Lintichiviti</u> M.D.			<b>22b. DATE SIGNED</b> <u>7/10/66</u>				
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W. A. Lintichiviti</u>			<b>22d. ADDRESS</b> <u>1105 Washington St. Rockville, Md</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>JULY 12, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>KRIDERS</u>			
<b>23d. LOCATION</b> (City, town or county) <u>WESTMINSTER</u>		(State) <u>MD</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>D. D. Hartzler &amp; Sons New Windsor</u>			<b>25a. REC'D BY REGISTRAR</b> DATE <u>JUL 12 1966</u>				
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			(Signature)				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





10206

CERTIFICATE OF DEATH

10198

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b - -		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> <b>15 - 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4213 Saul Road</b>				d. STREET ADDRESS <b>4213 Saul Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Sambuchelli Morreale</b>			4. DATE OF DEATH <b>July 31, 1966</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1912</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Joseph Sambuchelli</b>		
14. MOTHER'S MAIDEN NAME <b>Ciriaca DiFonzo</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - -		
16. SOCIAL SECURITY NO. <b>084-01-3171</b>			17. INFORMANT <b>Mrs. Joanne M. Feeley, 4209 Saul Rd.</b> Address <b>Kensington, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1533</b> IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma LIVER</b> DUE TO (b) <b>Carcinoma SIGMOID COLON</b> DUE TO (c) <b>2 1/2 yrs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 26, 1966</b> , to <b>July 31, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 26, 1966</b> , and that death occurred at <b>6:10 A.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>J. Blaine Fitzgerald</b>			22b. DATE SIGNED <b>7-31-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>J. Blaine Fitzgerald</b>			22d. ADDRESS <b>8218 Wisconsin Avenue Bethesda.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-3-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	23d. LOCATION (City or Town) <b>Silver Spring, Md.</b>	(County)	(State)
24. FUNERAL DIRECTOR <b>Joseph Gawlen's Sons, Inc.</b> Washington, D.C.			25a. REC'D BY REGISTRAR <b>AUG 4 1966</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

241111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10207					10199				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Freeland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Asbury Methodist Home for the Aged, Inc.</b>					d. STREET ADDRESS - - - -			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Ada</b>	Middle <b>Geneva</b>	Last <b>Morris</b>	4. DATE OF DEATH Month <b>July</b>		Day <b>29</b>	Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1879</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kept house</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Jefferson County, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George P. Morris</b>				14. MOTHER'S MAIDEN NAME <b>Louisa J. Wilhelm</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>185-28-1588</b>		17. INFORMANT Address <b>Asbury Methodist Home, Gaithersburg, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/1/63</b> , 19 to <b>7/29/66</b> , 19, that (I) (we) last saw the deceased alive on <b>7/29/66</b> , 19, and that death occurred at <b>1100 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Henry C. Scruggs M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/30/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>HENRY C. SCRUGGS M.D.</b>				22d. ADDRESS <b>5413 CEDAR LANE BETHESDA MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>8-2-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>McLion Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Freeland, Md.</b>			
24. FUNERAL DIRECTOR <b>David Stein</b>				ADDRESS <b>New Freedom, Pa.</b>		25a. REC'D BY REGISTRAR <b>gcharles judge</b>		25b. REGISTRAR'S SIGNATURE	
DATE <b>AUG 4 1966</b>									

10139

STATE OF DELAWARE

10139

Baltimore

Maryland

Delaware

Freeland

Delaware

Anders Methodist Home for the aged, Inc.

Freeland

Delaware

Delaware

Sept. 13, 1957

Jefferson County, Md.

Kept house

James L. Allen

George L. Morris

Anders Methodist Home, Baltimore, Md.

185-25-1528

10

1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10208  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
10200

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4723 Falcon Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jeresa</u> Middle <u>J.</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1881</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pittston, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Tierney</u>				14. MOTHER'S MAIDEN NAME <u>Bridgette Newcombe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-54-0710</u>		17. INFORMANT <u>4723 Falcon St. Address</u> <u>Leo A. Morrisson, Rockville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Bethesda, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 7, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 8 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1850

MEDICAL EXAMINATION OF DEATH

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10203

10201

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Barbara</b> Last <b>Mullis</b>		4. DATE OF DEATH Month <b>7</b> Day <b>12</b> Year <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/90</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>66</b>	11. IF UNDER 24 HRS. Months <b>12</b> Days <b>19</b> Hours <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Greenville, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Duckett</b>		14. MOTHER'S MAIDEN NAME <b>Ella Herring</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>244-26-5010B</b>	
17. INFORMANT <b>Ira B. Mullis</b>		Address <b>14700 Claude Lane Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY INSUFFICIENCY</b> 4201 DUE TO <b>RHEUMATIC HEART DISEASE-SEVERE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>YES</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 10, 1965</b> to <b>JULY 12, 1966</b> , that (II) (we) last saw the deceased alive on <b>July 12, 1966</b> , and that death occurred at <b>10:20 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Donald R. Lewis</b>		22b. DATE SIGNED <b>JUL 13, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald R. Lewis</b>		22d. ADDRESS <b>Olney, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 17, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wingate Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wingate, North Carolina</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>8434 Georgia Ave. Silver Spring, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>JUL 18 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

10301

DEPARTMENT OF DEATH

10301

Name		John Doe	
Address		123 Main St, City, State	
Age		35	
Sex		Male	
Race		White	
Religion		Catholic	
Marital Status		Single	
Occupation		Teacher	
Education		High School	
Date of Birth		1945-01-15	
Date of Death		1980-03-10	
Cause of Death		Heart Disease	
Place of Death		Home	
Time of Death		10:30 AM	
Witnesses		John Smith, Mary Doe	
Burial Place		St. Mary's Cemetery	
Burial Date		1980-03-15	
Burial Time		11:00 AM	
Burial Witness		John Doe	
Burial Date		1980-03-15	
Burial Time		11:00 AM	
Burial Witness		John Doe	

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8443-Woodcliff Court</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>8443 Woodcliff Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>J.</b> Last <b>Mulvihill</b>		4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1912</b> 9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metropolitan Fuel Co. New York</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John J. Mulvihill</b>		14. MOTHER'S MAIDEN NAME <b>Ann Reilly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW 2</b>		16. SOCIAL SECURITY NO. <b>113-12-6497</b>	
17. INFORMANT <b>Ann Mulvihill</b>		Address <b>8443 Woodcliff Court, Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute Coronary Insufficiency</b> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Heart Disease.</b> (c) <b>Coronary Artery Heart Disease.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Belden R. Reap</b>		Address (Street, city, town, or county) <b>Wheaton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>August 3, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas, Warner E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>AUG 3 1966</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1950

STATE OF TEXAS

1950

1950

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

10211

## CERTIFICATE OF DEATH

10203

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. <u>Chicago</u> <u>Illinois</u> <u>7/2</u> , COOK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chicago</u>	
c. LENGTH OF STAY IN lb <u>4 yrs</u>		d. STREET ADDRESS <u>4244 Broadway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mabel (Waters) Newton</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) <u>84</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Cincinnati Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Capt. Arthur Waters</u>		14. MOTHER'S MAIDEN NAME <u>Jesse Louise Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Lucile Fisher - Washington, D. C.</u>		3729 Corey Pl., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, left lower lobe</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>490X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Atherosclerosis; Congestive Heart Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>62</u> , to <u>July 1</u> , 19 <u>66</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>June 30</u> , 19 <u>66</u> , and that death occurred at <u>7:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Clifton R. Gruver</u>		22b. DATE SIGNED <u>7/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clifton R. GRUVER MD</u>		22d. ADDRESS <u>915 19th St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 7-3-66</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Glendale, Ohio</u>
24. FUNERAL DIRECTOR <u>Robert A. Ramsey</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 11 1966</u>	
ADDRESS <u>Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



ECSM

21921

Capt. Arthur Roberts  
Spectris Housekeeper  
Female white  
Nobel (Mrs)  
Kenniston Gardens 4 yrs  
Kenington 4 yrs  
Montgomery



10212

## CERTIFICATE OF DEATH

10204

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>7 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>69-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wellsville</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Maudie</u> Last <u>Norton</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-75</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Brown</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Madlock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>493X</u> DUE TO (c) <u>12 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>July 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 17</u> , 19 <u>66</u> , and that death occurred at <u>3:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James M. Cellar</u> M.D.		22b. DATE SIGNED <u>7-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James M. Cellar</u>		22d. ADDRESS <u>217 Carroll Ave. Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-20-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Wellsville, N.Y.</u>
24. FUNERAL DIRECTOR <u>Ives Funeral Home, Inc.</u> by: <u>Ben E. Rogers</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JUL 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

40501

513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10213					10205				
1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i> <i>Washington Sanatorium</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>2301-11th NW</i> b. COUNTY <i>Wash DC</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanatorium</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First <i>Dollie</i> Middle <i>Ann</i> Last <i>Oliver</i>			4. DATE OF DEATH		Month <i>7</i> Day <i>4</i> Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/6/90</i>		9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>Yes</i>		
13. FATHER'S NAME <i>William Oliver</i>					14. MOTHER'S MAIDEN NAME <i>Indiana Henderson</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Minor Oliver Son</i>			Address <i>7415-9th St. NW</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 443X DUE TO <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Hypertensive cardiac disease</i> (c)								INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> <i>General</i> <i>Force</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>June 30, 1966</i> , to <i>July 4, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 30, 1966</i> , and that death occurred at <i>9:52 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>St. H. Hadley MD</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>July 4 66</i>		
22c. PHYSICIAN'S NAME (Type) <i>St. H. Hadley MD</i>					22d. ADDRESS <i>7601 Nichols Ave SW</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>7-8-66</i>			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Arlington, Virginia</i>		
24. FUNERAL DIRECTOR <i>John T. Plummer Co</i>					ADDRESS <i>3015 12th St NW</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		
					DATE <i>JUL 12 1966</i>		25b. REGISTRAR'S SIGNATURE		

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1850

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10214					10206				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Texas</b> b. COUNTY <b>Houston</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Houston</b> d. STREET ADDRESS <b>4041 Woodfox Street</b>				
c. LENGTH OF STAY IN 1b <b>68 days</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Elizabeth Ormand</b>			4. DATE OF DEATH Month Day Year <b>July 10, 1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 October 1920</b>		9. AGE (In years last birthday) <b>45</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joe Robert Lester</b>					14. MOTHER'S MAIDEN NAME <b>Maybelle Kirk</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>450-18-9980</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Md. 20014</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septicemia</b> DUE TO (c) <b>Mycosis Fungoides</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 days</b> <b>15 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>May 3, 1966</b> , to <b>July 10, 1966</b> , that <b>we</b> (we) last saw the deceased alive on <b>July 10, 1966</b> , and that death occurred at <b>8:51M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>William R. Levis</b>								22b. DATE SIGNED <b>July 10, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William R. Levis, M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>			23b. DATE THEREOF <b>7/11/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>?</b>		23d. LOCATION (City, town or county) (State) <b>Texas</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>					ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>

Bur-Transit 7/11/1966  
 Robert A. Humphrey, Bethesda, Maryland  
 William R. Lewis, M.D.  
 The Clinical Center, National  
 Institutes of Health, Bethesda, Md.  
 \* July 10, 1966  
 May 3, 66  
 July 10, 66  
 8:51  
 A.M.  
 15 years  
 4 days  
 4 days  
 Special Injections  
 Septicemia  
 Inflammation  
 No  
 450-11-2480  
 The Clinical Center, Bethesda, Md. 20014  
 The Medical Record  
 Mayfield Hill  
 Arkansas  
 USA  
 8 11 1  
 July 10, 66  
 68 days  
 Houston  
 Texas  
 Montgomery  
 Bethesda



TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> c. LENGTH OF STAY IN 1b <b>10 YRS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4000 HALSEY STREET</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. STREET ADDRESS <b>4000 HALSEY STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>NONE</b> Last <b>ORSETT</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 16 1888</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H-Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BUDAORS HUNGARY</b>		12. CITIZEN OF WHAT COUNTRY? <b>HUNGARY</b>	
13. FATHER'S NAME <b>KARL BUS</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA NIKL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-54-9705</b>	
17. INFORMANT <b>EMILY HYATT</b>		Address <b>4000 HALSEY ST KENSINGTON</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOM OF PANCREAS</b> 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PERNICIOUS ANEMIA</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>JUNE</b> , 19 <b>63</b> , to <b>7/2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1966</b> , and that death occurred at <b>7AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry W. Stout</b>		22b. DATE SIGNED <b>7/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY W. STOUT MD</b>		22d. ADDRESS <b>10011 GEORGIA AVE SILVER SPRING MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>July 5, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc</b>		25a. REC'D BY REGISTRAR <b>JUL 7 1966</b>	
ADDRESS <b>8655 Ga. Ave. Silver Springs, Md</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

2. The second part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

3. The third part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

4. The fourth part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

5. The fifth part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

6. The sixth part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

7. The seventh part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

8. The eighth part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

9. The ninth part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

10. The tenth part of the report is a detailed description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10216

## CERTIFICATE OF DEATH

10208

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>		d. STREET ADDRESS <b>3939 NEWDALE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OSCAR H. OSTERMAN</b>						4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>19 66</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/28.1883</b>		9. AGE (In years last birthday) <b>82</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Henry Osterman</b>	
14. MOTHER'S MAIDEN NAME <b>Anna</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give wor or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-30-5684A</b>		17. INFORMANT <b>Mrs. Mason Weadon - Chevy Chase, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from <b>June 18, 1966</b> , to <b>July 9, 1966</b> , that (I) last saw the deceased alive on <b>July 8, 1966</b> , and that death occurred at <b>2:30 A.M.</b> from causes and on the date stated above.													
22a. SIGNATURE <b>Gene U. Cohen</b>				22b. DATE SIGNED <b>July 9 66</b>		22c. PHYSICIAN'S NAME (Type) <b>Gene U. Cohen M.D.</b>		22d. ADDRESS <b>1106 Spring St. Silver Spring, Md</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>7/12/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington Dist. of Col.</b>		24. BURIAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Marylandx</b>		25a. REC'D BY REGISTRAR <b>JUL 13 1966</b>	
								25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10010

10010

10010

0015 Stonington Ave.

Stonington - Chevy Chase, Md.

Stonington - Chevy Chase, Md. 10010

Stonington - Chevy Chase, Md. 10010

CERTIFICATE OF DEATH

10209

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>		d. STREET ADDRESS <u>12404 Village Square Tr.</u>	
3. NAME OF DECEASED (Type or print) <u>MALE Baby JOHN J. Ott</u>		4. DATE OF DEATH <u>July 25 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/23/66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) yrs. <u>2</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph J.</u>		14. MOTHER'S MAIDEN NAME <u>Josephine F.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Joseph J Ott</u>		Address <u>12404 Village Sq. Rockville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u> <u>7730</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> , 19 <u>66</u> , to <u>7/25</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>7/25</u> 19 <u>66</u> , and that death occurred at <u>10 a.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph A. Dugan</u>		22b. DATE SIGNED <u>7/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph A. Dugan</u>		22d. ADDRESS <u>50 W. Edmonston Dr., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>JUL 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

10801

RECORD OF DEATH

10801

RECORD OF DEATH



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	c. LENGTH OF STAY IN 1b <b>23 HOURS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	<b>Chevy Chase, Md</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>3221 Brooklawn Ter.</b>	
3. NAME OF DECEASED (Type or print) <b>Philip</b> First <b>PEARL</b> Last		4. DATE OF DEATH Month <b>7</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-1-1904</b> 62 yrs.
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PUBLIC RELATIONS MAN</b>	11. BIRTHPLACE (state or foreign country) <b>U.S.A. - New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Pearl</b>	
14. MOTHER'S MAIDEN NAME <b>Sophie Keilson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT <b>Evelyn Mandelbaum</b> Address <b>Brant, N.Y. 1015 Grand Concourse</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction Acute</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>23 hrs.</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John G. Ball, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>7-13-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash. DC.</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10310

10310

John B. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>33 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Connecticut</b> b. COUNTY <b>New London</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Groton</b> d. STREET ADDRESS <b>16 Country Club Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Michael Lee Pearsall</b>			4. DATE OF DEATH <b>July 16, 1966</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 March 1945</b>		9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>16</b> <b>19</b> <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yeoman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>			11. BIRTHPLACE (County & State, or foreign country) <b>England</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Benjamin L. VanCamp</b>					14. MOTHER'S MAIDEN NAME <b>Nora Knight</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>1963-1965</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Md.</b>			Address <b>20014</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Stem Compression</b> <b>1930</b> DUE TO <b>Increased intracranial pressure</b> left fronto-parietal DUE TO <b>Glioblastoma multiforme of / area</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 months</b> <b>18 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <del>an</del> (this hospital) attended the deceased from <b>June 13</b> , 19 <b>66</b> , to <b>July 16</b> , 19 <b>66</b> , that <del>we</del> last saw the deceased alive on <b>July 16</b> , 19 <b>66</b> , and that death occurred at <b>1245</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>D. B. Gainsburg, M.D.</b>					22b. DATE SIGNED <b>16 July 1966</b>						
22c. PHYSICIAN'S NAME (Type) <b>Duane B. Gainsburg, M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>7/18/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CREM.</b>			23d. LOCATION (City, town or county) (State) <b>COLUMBIA MANOR PR6606 MD</b>				
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS, INC. - 511 S. SP. MD</b>					25a. REC'D BY REGISTRAR DATE <b>JUL 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

10811

DEPT. OF HEALTH

10811

Continued

Continued

Division

33 days

Bedside

15 County Club Road

The Clinical Center, Bethesda, Maryland

July 15, 1965

Payroll

Lee

Michael

21

7 March 1965

Wife

Male

USA

England

U.S. Navy

Yeoman

Home Rights

Benjamin L. Vancamp

The Medical Record  
The Clinical Center, Bethesda, Md. ROOM

509-45-4377

1965-1965

was

Brain Stem Compression

3 days

Increased intracranial pressure

5 months

left fronto-parietal

Glipolastone multiforme of / area

18 months

July 15, 1965

July 15, 1965

1965

June 15

1965

July 15, 1965

15 July 1965

The Clinical Center, Medical

Institution of Health, Bethesda, Maryland

Donna B. Gathorne, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10220

10212

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>District of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN TB <i>53 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>Thorn</i> Last <i>Perry</i>		4. DATE OF DEATH Month <i>7</i> Day <i>30</i> Year <i>1966</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-22-'80</i>
9. AGE (In years last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>CHENNING</i> <i>Hernton Chenning</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Bell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO. <i>Hospital Records</i>	
17. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Loss of appetite &amp; general debility + decline</i> DUE TO <i>Chronic illness - general &amp; central</i> (b) <i>Old age &amp; debility</i> DUE TO <i>Can of Sarcin</i> (c) <i>...</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk - 2 wks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	24. (City or town) (County) (State)
25. I certify that (I) (this hospital) attended the deceased from <i>June 8 -</i> , 1966, to <i>July 30</i> , 1966 that (I) (we) last saw the deceased alive on <i>July 30 - 1966</i> , and that death occurred at <i>8:00 A.M.</i> from causes and on the date stated above.			
26. SIGNATURE <i>CH H. Holston</i>		27. DATE SIGNED	
28. PHYSICIAN'S NAME (Type) <i>Chas H. W. Lohman</i>		29. ADDRESS <i>7401 Blue Rd NW Wash DC</i>	
30. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	31. DATE THEREOF <i>Aug. 2, 1966</i>	32. NAME OF CEMETERY OR CREMATORY <i>Blennwood Cemetery</i>	33. LOCATION (City or town) (County) (State) <i>Washington D.C.</i>
34. FUNERAL DIRECTOR <i>Arthur Watters, 254 Carroll St NW Wash. D.C.</i>		35. REC'D BY REGISTRAR <i>...</i>	
36. ADDRESS		37. REGISTRAR'S SIGNATURE <i>...</i>	
38. DATE		39. AUG 3 1966	

10318

CERTIFICATE OF DEATH

10330

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C. 20001



10221

1. PLACE OF BIRTH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>29 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marlow Heights</b> d. STREET ADDRESS <b>2708 Keith Street, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Gerald</b> Last <b>PERRY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1923</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months <b>43</b>	11. IF UNDER 24 HRS. Days <b>43</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Beckley, West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert Phillip Perry</b>	
14. MOTHER'S MAIDEN NAME <b>Ruby Thelma Eads</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 1941-1961</b>	
16. SOCIAL SECURITY NO. <b>176 32 008</b>		17. INFORMANT <b>Mrs. Marie T. Perry, 2708 Keith Street/</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> <b>163x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____		19. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (X) (this hospital) attended the deceased from <b>June 13, 1966</b> , to <b>July 12, 1966</b> , that (X) (we) last saw the deceased alive on <b>July 12, 1966</b> , and that death occurred at <b>8:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph T. Mullen</b>		22b. DATE SIGNED <b>July 13, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph T. Mullen, M. D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 15-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Simmons Brothers</b> <b>1661 Goodhope Rd., S. E. Washington, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

VR A15 (4)  
20 M 1/66

10519

REPORT OF DEATH

10001

Name of Deceased		Date of Death	
Place of Death		Time of Death	
Cause of Death		Manner of Death	
Medical History		Previous Illnesses	
History of Present Illness		Treatment	
History of Trauma		Postmortem Examination	
History of Abuse		Other Information	
Signature of Physician		Signature of Coroner	
Signature of Medical Examiner		Signature of Death Investigator	
Signature of Funeral Home		Signature of Burial Place	
Signature of Next of Kin		Signature of Social Security Administration	
Signature of State Health Department		Signature of Federal Bureau of Investigation	

TO OBTAIN INFORMATION CONCERNING THE DEATH OF A PERSON, CONTACT THE BUREAU OF INVESTIGATION, DEPARTMENT OF JUSTICE, WASHINGTON, D. C. 20535.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10222

## CERTIFICATE OF DEATH

10214

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>				d. STREET ADDRESS <u>324 Prince George St.</u>			
3. NAME OF DECEASED (Type or print) LILY <u>Lilly</u> First Middle Last R. <u>R.</u> PHELPS <u>Phelps</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 29, 1885</u>	
				9. AGE in years last birthday <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-10-0521-B</u>		17. INFORMANT <u>503 5th St.</u> <u>Mrs. Elizabeth Quill, Laurel, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> <u>4201</u> DUE TO <u>associated terminal congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic heart disease and</u> (c) <u>generalized weakness of heart</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Iron deficiency anemia (2 old fractures)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>65</u> , to <u>7-13</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>7-9</u> 19 <u>66</u> , and that death occurred at <u>4:10</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John R. Spencer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-13-66</u>	
22c. (PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>				22d. ADDRESS <u>BURTONSVILLE, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 15, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Laurel, Maryland</u>	
24. FUNERAL DIRECTOR <u>Harold S. Wadew</u>				ADDRESS <u>550 Wash. Blvd., Laurel, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10223

CERTIFICATE OF DEATH

10215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15 days - 11 hrs - 5 min</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15 - 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>9507 Caroline Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Grendle</u> Middle <u>Pierce</u> Last		4. DATE OF DEATH <u>July</u> Month <u>6</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-97</u> 9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Gov't.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WW2 - Infantry</u>		16. SOCIAL SECURITY NO. <u>217-44-2308</u> 17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inter cerebral, Cerebral, Cardiac</u> 4201 DUE TO <u>Cerebral thrombosis</u> (b) <u>Coronary thrombosis - Myocardial infarction</u> DUE TO <u>old &amp; recent</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/20/</u> , 19 <u>66</u> , to <u>7/6/</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/3/</u> , 19 <u>66</u> , and that death occurred at <u>3:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Chas H Wolohan</u>		22b. DATE SIGNED <u>6 July 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohan</u>		22d. ADDRESS <u>Wash. San. and Hosp., Takoma Park</u> Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8 July 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>ALFREDI FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>W.V. DC 20012</u>	25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>
		DATE <u>JUL 8</u>	19 <u>66</u>

10512

ASSOCIATES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> 15-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Althea Woodland Nursing Home</i>					d. STREET ADDRESS <i>8105 Eastern Avenue</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Charlotte</i> Middle <i>M</i> Last <i>Pohanka</i>			4. DATE OF DEATH Month <i>July</i> Day <i>30</i> Year <i>1966</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 30, 1893</i>		9. AGE (In years last birthday) <i>73</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>New York City, N. Y.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Joseph Ruff</i>				14. MOTHER'S MAIDEN NAME <i>Charlotte KXX Kehlner</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>John J. Pohanka</i>		Address <i>4808 Westburg Rd. Rockville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 442 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Cardio-Vascular Renal disease</i> DUE TO (c) <i></i>								INTERVAL BETWEEN ONSET AND DEATH <i>5 mo.</i> <i>8 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>April 30, 1966</i> to <i>July 30, 1966</i> that (I) (we) last saw the deceased alive on <i>July 25, 1966</i> , and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Charles W. Harnsberger</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7/31/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>CHARLES W. HARNSEBERGER</i>				22d. ADDRESS <i>4201 NEW HAMPTON AVE. N.W.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 3, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Prince Georges Co., Md.</i>		
24. FUNERAL DIRECTOR <i>John B. Thomas</i> <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>g Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	

25501

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10225

## CERTIFICATE OF DEATH

10217

1. PLACE OF DEATH a. COUNTY <u>MONT.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Silver Spring Md.</u> b. COUNTY <u>Silver Spring Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Nursing Home 8700 Jones mill rd Silver Spring Chevy Chase, Md</u>		d. STREET ADDRESS <u>1313 - 16th St. N. W.</u>	
3. NAME OF DECEASED (Type or print) <u>Miss Eunice M. PRINCE</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13th</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3, 1909</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>UNION. South CARO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>PRINCE, James G.</u>		14. MOTHER'S MAIDEN NAME <u>ARMeda, Bredgs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Nursing Home Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Atherosclerosis - inoperable</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>with increasing intracranial pressure</u> (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>October, 1965</u> to <u>July 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1966</u> , and that death occurred at <u>11:00 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIANS NAME (Type) <u>ALBERT H. GROLLMAN MD</u>		22d. ADDRESS <u>1186 SPRING ST SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>7/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>  </u>	23d. LOCATION (City or Town) (County) (State) <u>Union, South Carolina</u>
24. FUNERAL DIRECTOR <u>The S. H. Hines Co. Washington, D.C.</u>		25. REC'D BY REGISTRAR DATE <u>JUL 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

10217

CERTIFICATE OF DRAIN

10222

WATER

Belvedere

Belvedere

Miss Emma V. Prince

Female W

Government class

Prince James C

No

General

with

with

with

with

with

with

with

with

with

with

with